HARDIN COUNTY GENERAL HOSPITAL

TITLE XVIII MEDICARE COST REPORT

PROVIDER NO. 14-1328

YEAR ENDED MARCH 31, 2008

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I & II

INTERMEDIARY USE ONLY: [ ] AUDITED [ ] DESK REVIEWED DATE RECEIVED _____ INTERMEDIARY NO. _____ [ ] INITIAL [ ] FINAL [ ] RE-OPENING [ ] MCR CODE

PART I - CERTIFICATION

CHECK APPLICABLE BOX XX ELECTRONICALLY FILED COST REPORT __ MANUALLY SUBMITTED COST REPORT DATE: _08/20/2008 TIME: _09:19____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HARDIN COUNTY GENERAL HOSPITAL (14-1328) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2007 AND ENDING 03/31/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 08/20/2008 09:19
CL6U2s95ThS6fWj0XEFOWM3Hb94aS0
GF8eN0V.3cFmZtBtnoYu2UIZIjio8H
1WIQ0P9Hrz0imHEq

PI Encryption: 08/20/2008 09:19
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u4l5X0hDGBjGR.GzZmcg33ZQm9P86O
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(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

| | | TITLE V | TITLE XVIII PART A | TITLE XVIII PART B | TITLE XIX | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| 1 | HOSPITAL | | -43277 | 8949 | 471533 | 1 |
| 2 | SUBPROVIDER I | | | | | 2 |
| 3 | SWING BED - SNF | | -2680 | | | 3 |
| 4 | SWING BED - NF | | | | | 4 |
| 5 | SKILLED NURSING FACILITY | | | | | 5 |
| 6 | NURSING FACILITY | | | | | 6 |
| 7 | HOME HEALTH AGENCY | | | | | 7 |
| 8 | OUTPATIENT REHABILITATION PROVIDER | | | | | 8 |
| 9 | RURAL HEALTH CLINIC I | | | 101598 | | 9 |
| 100 | TOTAL | | -45957 | 110547 | 471533 | 100 |

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: FERRELL ROAD P.O.BOX: 2467 1
1.01 CITY: ROSICLARE STATE: IL ZIP CODE: 62982 COUNTY: HARDIN 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

| | COMPONENT | COMPONENT NAME | PROVIDER NUMBER | DATE CERTIFIED | PAYMENT SYSTEM (P,T,O OR N) V XVIII | XIX | |
|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | |
| 2 | HOSPITAL | HARDIN COUNTY GENERAL HOSPITAL | 14-1328 | 07/09/2003 | N | O | O | 2 |
| 3 | SUBPROVIDER I | | | | | | | 3 |
| 4 | SWING BEDS - SNF | HARDIN COUNTY SWING BED | 14-Z328 | 07/09/2003 | N | O | N | 4 |
| 5 | SWING BEDS - NF | | | | | | | 5 |
| 6 | HOSPITAL-BASED SNF | | | | | | | 6 |
| 7 | HOSPITAL-BASED NF | | | | | | | 7 |
| 8 | HOSPITAL-BASED OLTC | | | | | | | 8 |
| 9 | HOSPITAL-BASED HHA | | | | | | | 9 |
| 11 | SEPARATELY CERTIFIED ASC | | | | | | | 11 |
| 12 | HOSPITAL-BASED HOSPICE | | | | | | | 12 |
| 14 | HOSP-BASED RHC | HARDIN COUNTY RHC | 14-3479 | 04/03/2006 | N | O | N | 14 |
| 15 | OUTPATIENT REHABILITATION PROVID | | | | | | | 15 |
| 16 | RENAL DIALYSIS | | | | | | | 16 |

| | | | |
|---|---|---|---|
| 17 | COST REPORTING PERIOD (MM/DD/YYYY) | FROM: 04/01/2007 TO: 03/31/2008 | 17 |
| | | 1 2 | |
| 18 | TYPE OF CONTROL | 2 | 18 |

TYPE OF HOSPITAL/SUBPROVIDER

| | | | |
|---|---|---|---|
| 19 | HOSPITAL | 1 | 19 |
| 20 | SUBPROVIDER I | | 20 |

OTHER INFORMATION

| | | | | |
|---|---|---|---|---|
| 21 | INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. | | | 21 |
| 21.01 | DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? | | | 21.01 |
| 21.02 | HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE. | | | 21.02 |
| 21.03 | ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. | 2 | 99914 | 21.03 |
| 21.04 | FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. | | | 21.04 |
| 21.05 | FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL. | | | 21.05 |
| 21.06 | DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO. | NO | | 21.06 |
| 22 | ARE YOU CLASSIFIED AS A REFERRAL CENTER? | NO | | 22 |
| 23 | DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW | NO | | 23 |
| 23.01 | IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3. | | | 23.01 |
| 23.02 | IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. | | | 23.02 |
| 23.03 | IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. | | | 23.03 |
| 23.04 | IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. | | | 23.04 |
| 23.05 | IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. | | | 23.05 |
| 23.06 | IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. | | | 23.06 |
| 23.07 | IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. | | | 23.07 |
| 24 | IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3. | | | 24 |
| 24.01 | IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3. | | | 24.01 |
| 25 | IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R? | NO | | 25 |
| 25.01 | IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? | NO | | 25.01 |
| 25.02 | IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II. | NO | | 25.02 |
| 25.03 | AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. | NO | | 25.03 |
| 25.04 | ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2 | NO | | 25.04 |
| 25.05 | HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) | | | 25.05 |
| 25.06 | HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS) | | | 25.06 |

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| 26 | IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. | | | | 26 |
| 26.01 | ENTER THE APPLICABLE SCH DATES: | BEGINNING: | | ENDING: | 26.01 |
| 26.03 | IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA. | | | | 26.03 |
| 26.04 | IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): | | | | 26.04 |
| | BEGINNING: | ENDING: | BEGINNING: | ENDING: | |
| 27 | DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2. | YES | 07/09/2003 | | 27 |
| 28 | IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02. | | | | 28 |
| 28.01 | IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st | | | | 28.01 |
| 28.02 | ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY. | | | | 28.02 |

A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

| | | | | |
|---|---|---|---|---|
| 28.03 | STAFFING | 0.00 | N | 28.03 |
| 28.04 | RECRUITMENT | 0.00 | N | 28.04 |
| 28.05 | RETENTION OF EMPLOYEES | 0.00 | N | 28.05 |
| 28.06 | TRAINING | 0.00 | N | 28.06 |
| 28.07 | OTHER (SPECIFY) | | | 28.07 |

| | | | |
|---|---|---|---|
| 29 | IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? | NO | 29 |
| 30 | DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff. | YES | 30 |
| 30.01 | IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70. | NO | 30.01 |
| 30.02 | IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? | NO | 30.02 |
| 30.03 | IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000) | NO | 30.03 |
| 30.04 | IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II. | NO | 30.04 |
| 31 | IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). | NO | 31 |

MISCELLANEOUS COST REPORTING INFORMATION

| | | | |
|---|---|---|---|
| 32 | IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. | NO | 32 |
| 33 | IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2. | NO | 33 |
| 34 | IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA? | NO | 34 |
| 35 | HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? | NO | 35 |

| | | V | XVIII | XIX | |
|---|---|---|---|---|---|
| | PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL | 1 | 2 | 3 | |
| 36 | DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? | NO | NO | NO | 36 |
| 36.01 | DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320? | NO | NO | NO | 36.01 |
| 37 | DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? | NO | NO | NO | 37 |
| 37.01 | IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE? | NO | NO | NO | 37.01 |

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

| | | | |
|---|---|---|---|
| 38 | DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? | YES | 38 |
| 38.01 | IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? | NO | 38.01 |
| 38.02 | DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? | NO | 38.02 |
| 38.03 | ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? | NO | 38.03 |
| 38.04 | DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? | NO | 38.04 |
| 40 | ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE. | NO | 40 |
| 40.01 | NAME: FI/CONTRACTOR'S NAME: | FI/CONTRACTOR'S NUMBER: | 40.01 |
| 40.02 | STREET: | P.O.BOX: | 40.02 |
| 40.03 | CITY: | STATE: ZIP CODE: | 40.03 |
| 41 | ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? | YES | 41 |
| 42 | ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? | YES | 42 |
| 42.01 | ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? | YES | 42.01 |
| 42.02 | ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? | YES | 42.02 |
| 43 | ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS? | NO | 43 |
| 44 | IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY? | NO | 44 |
| 45 | HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2. | NO | 45 |
| 45.01 | WAS THERE A CHANGE IN THE STATISTICAL BASIS? | | 45.01 |
| 45.02 | WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? | | 45.02 |
| 45.03 | WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? | | 45.03 |
| 46 | IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. | | 46 |

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

| | | PART A | PART B | OUTPATIENT ASC | OUTPATIENT RADIOLOGY | OUTPATIENT DIAGNOSTIC | |
|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | |
| 47 | HOSPITAL | N | N | N | N | N | 47 |
| 48 | SUBPROVIDER I | N | N | N | N | N | 48 |
| 49 | SKILLED NURSING FACILITY | N | N | | | | 49 |
| 50 | HOME HEALTH AGENCY | N | N | | | | 50 |

| | | | |
|---|---|---|---|
| 52 | DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? | NO | 52 |
| 52.01 | IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV. | NO | 52.01 |
| 53 | IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. | | 53 |
| 53.01 | MDH PERIOD: BEGINNING: ENDING: | | 53.01 |
| 54 | LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: | | 54 |
| | PREMIUMS: 66800 PAID LOSSES: AND/OR SELF INSURANCE: | | |
| 54.01 | ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. | NO | 54.01 |
| 55 | DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO. | NO | 55 |

| | | DATE | Y/N | LIMIT | Y/N | FEES | |
|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 | |
| 56 | ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. | / / | NO | 0.00 | NO | | 56 |

| | | | |
|---|---|---|---|
| 57 | ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? | NO | 57 |
| 58 | ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. | NO | 58 |
| 58.01 | IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS) | | 58.01 |
| 59 | ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS) | NO | 59 |

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

| | | | |
|---|---|---|---|
| 60 | ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS) | NO | 60 |
| 60.01 | IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.) | | 60.01 |

MULTICAMPUS

| | | | |
|---|---|---|---|
| 61 | DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. | NO | 61 |

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

| | COUNTY: | STATE: | ZIP CODE | CBSA | FTE/ CAMPUS |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/2000)



HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

| | COMPONENT | NO. OF BEDS 1 | BED DAYS AVAILABLE 2 | CAH PATIENT HOURS 2.01 | I/P DAYS / O/P VISITS / TRIPS TITLE V 3 | TITLE XVIII 4 | LTCH NONCOVERED DAYS 4.01 | TITLE XIX 5 | OBS. BEDS ADMITTED 5.01 | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS | 25 | 9150 | 69024.00 | | 2215 | | 402 | | 1 |
| 2 | HMO | | | | | | | | | 2 |
| 3 | HOSPITAL ADULTS & PEDS - SWING BED SNF | | | | | 898 | | | | 3 |
| 4 | HOSPITAL ADULTS & PEDS - SWING BED NF | | | | | | | 186 | | 4 |
| 5 | TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS | 25 | 9150 | 69024.00 | | 3113 | | 588 | | 5 |
| 6 | INTENSIVE CARE UNIT | | | | | | | | | 6 |
| 7 | CORONARY CARE UNIT | | | | | | | | | 7 |
| 8 | BURN INTENSIVE CARE UNIT | | | | | | | | | 8 |
| 9 | SURGICAL INTENSIVE CARE UNIT | | | | | | | | | 9 |
| 10 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | | | 10 |
| 11 | NURSERY | | | | | | | | | 11 |
| 12 | TOTAL HOSPITAL | 25 | 9150 | 69024.00 | | 3113 | | 588 | | 12 |
| 13 | RPCH VISITS | | | | | | | | | 13 |
| 14 | SUBPROVIDER I | | | | | | | | | 14 |
| 15 | SKILLED NURSING FACILITY | | | | | | | | | 15 |
| 16 | NURSING FACILITY | | | | | | | | | 16 |
| 17 | OTHER LONG TERM CARE | | | | | | | | | 17 |
| 18 | HOME HEALTH AGENCY | | | | | | | | | 18 |
| 20 | ASC (DISTINCT PART) | | | | | | | | | 20 |
| 21 | HOSPICE (DISTINCT PART) | | | | | | | | | 21 |
| 23 | O/P REHAB PROVIDER | | | | | | | | | 23 |
| 24 | RHC I | | | | | 3964 | | | | 24 |
| 25 | TOTAL | 25 | | | | | | | | 25 |
| 26 | OBSERVATION BED DAYS | | | | | | | 120 | 10 | 26 |
| 27 | AMBULANCE TRIPS | | | | | | | | | 27 |
| 28 | EMPLOYEE DISCOUNT DAYS | | | | | | | | | 28 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

| | COMPONENT | I/P DAYS / O/P VISITS / TRIPS | | | | INTERNS & RES FTES | | | FULL TIME EQUIV | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | OBS. BEDS NOT ADMITTED 5.02 | TOTAL ALL PATIENTS 6 | OBS. BEDS ADMITTED 6.01 | OBS. BEDS NOT ADMITTED 6.02 | TOTAL 7 | LESS I&R REPL NON-PHYS ANES 8 | NET 9 | EMPLOYEES ON PAYROLL 10 | NONPAID WORKERS 11 | |
| 1 | HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS | | 2876 | | | | | | | | 1 |
| 2 | HMO XIX | | | | | | | | | | 2 |
| 3 | HOSPITAL ADULTS & PEDS - SWING BED SNF | | 898 | | | | | | | | 3 |
| 4 | HOSPITAL ADULTS & PEDS - SWING BED NF | | 186 | | | | | | | | 4 |
| 5 | TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS | | 3960 | | | | | | | | 5 |
| 6 | INTENSIVE CARE UNIT | | | | | | | | | | 6 |
| 7 | CORONARY CARE UNIT | | | | | | | | | | 7 |
| 8 | BURN INTENSIVE CARE UNIT | | | | | | | | | | 8 |
| 9 | SURGICAL INTENSIVE CARE UNIT | | | | | | | | | | 9 |
| 10 | OTHER SPECIAL CARE (SPECIFY) | | | | | | | | | | 10 |
| 11 | NURSERY | | | | | | | | | | 11 |
| 12 | TOTAL HOSPITAL | | 3960 | | | | | | 118.51 | | 12 |
| 13 | RPCH VISITS | | | | | | | | | | 13 |
| 14 | SUBPROVIDER I | | | | | | | | | | 14 |
| 15 | SKILLED NURSING FACILITY | | | | | | | | | | 15 |
| 16 | NURSING FACILITY | | | | | | | | | | 16 |
| 17 | OTHER LONG TERM CARE | | | | | | | | | | 17 |
| 18 | HOME HEALTH AGENCY | | | | | | | | | | 18 |
| 20 | ASC (DISTINCT PART) | | | | | | | | | | 20 |
| 21 | HOSPICE (DISTINCT PART) | | | | | | | | | | 21 |
| 23 | O/P REHAB PROVIDER | | | | | | | | | | 23 |
| 24 | RHC I | | 11106 | | | | | | 16.20 | | 24 |
| 25 | TOTAL | | | | | | | | 134.71 | | 25 |
| 26 | OBSERVATION BED DAYS | 110 | 439 | 41 | 398 | | | | | | 26 |
| 27 | AMBULANCE TRIPS | | | | | | | | | | 27 |
| 28 | EMPLOYEE DISCOUNT DAYS | | | | | | | | | | 28 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

| | COMPONENT | DISCHARGES - TITLE V 12 | DISCHARGES - TITLE XVIII 13 | DISCHARGES - TITLE XIX 14 | DISCHARGES - TOTAL ALL PATIENTS 15 | |
|---|---|---|---|---|---|---|
| 1 | HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS | | 565 | 112 | 761 | 1 |
| 2 | HMO XIX | | | | | 2 |
| 3 | HOSPITAL ADULTS & PEDS - SWING BED SNF | | | | | 3 |
| 4 | HOSPITAL ADULTS & PEDS - SWING BED NF | | | | | 4 |
| 5 | TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS | | | | | 5 |
| 6 | INTENSIVE CARE UNIT | | | | | 6 |
| 7 | CORONARY CARE UNIT | | | | | 7 |
| 8 | BURN INTENSIVE CARE UNIT | | | | | 8 |
| 9 | SURGICAL INTENSIVE CARE UNIT | | | | | 9 |
| 10 | OTHER SPECIAL CARE (SPECIFY) | | | | | 10 |
| 11 | NURSERY | | | | | 11 |
| 12 | TOTAL HOSPITAL | | 565 | 112 | 761 | 12 |
| 13 | RPCH VISITS | | | | | 13 |
| 14 | SUBPROVIDER I | | | | | 14 |
| 15 | SKILLED NURSING FACILITY | | | | | 15 |
| 16 | NURSING FACILITY | | | | | 16 |
| 17 | OTHER LONG TERM CARE | | | | | 17 |
| 18 | HOME HEALTH AGENCY | | | | | 18 |
| 20 | ASC (DISTINCT PART) | | | | | 20 |
| 21 | HOSPICE (DISTINCT PART) | | | | | 21 |
| 23 | O/P REHAB PROVIDER | | | | | 23 |
| 24 | RHC I | | | | | 24 |
| 25 | TOTAL | | | | | 25 |
| 26 | OBSERVATION BED DAYS | | | | | 26 |
| 27 | AMBULANCE TRIPS | | | | | 27 |
| 28 | EMPLOYEE DISCOUNT DAYS | | | | | 28 |

RHC I
COMPONENT NO: 14-3479

WORKSHEET S-8

PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

| | | | |
|---|---|---|---|
| 1 | STREET: 6 FERRELL ROAD | | 1 |
| 1.01 | CITY: ROSICLARE | STATE: IL ZIP CODE: 62982 COUNTY: HARDIN | 1.01 |
| 2 | DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN | | 2 |

| SOURCE OF FEDERAL FUNDS: | GRANT AWARD 1 | DATE 2 | |
|---|---|---|---|
| 3 | COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) | / / | 3 |
| 4 | MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) | / / | 4 |
| 5 | HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) | / / | 5 |
| 6 | APPALACHIAN REGIONAL COMMISSION | / / | 6 |
| 7 | LOOK-ALIKES | / / | 7 |
| 8 | OTHER | / / | 8 |

| PHYSICIAN INFORMATION: | PHYSICIAN NAME | BILLING NO. | |
|---|---|---|---|
| 9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT | MARCOS SUNGA, MD | C43012 | 9 |
| 9.01 | ELADIO CHATTO, MD | E98343 | 9.01 |
| 9.02 | SANJAY BOSE | G78722 | 9.02 |
| 9.03 | PAM ATKINSON | P10866 | 9.03 |
| 9.04 | LEANNE DENEAL | | 9.04 |

| | PHYSICIAN NAME | HOURS | |
|---|---|---|---|
| 10 | SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD | | 10 |

| | | | |
|---|---|---|---|
| 11 | DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS) | NO | 11 |

FACILITY HOURS OF OPERATIONS (1)

| | TYPE OPERATION | SUNDAY FROM | SUNDAY TO | MONDAY FROM | MONDAY TO | TUESDAY FROM | TUESDAY TO | WEDNESDAY FROM | WEDNESDAY TO | THURSDAY FROM | THURSDAY TO | FRIDAY FROM | FRIDAY TO | SATURDAY FROM | SATURDAY TO | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | |
| 12 | CLINIC | | | 900 | 1700 | 900 | 1700 | 900 | 1700 | 900 | 1700 | 900 | 1700 | | | 12 |

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

| | | | |
|---|---|---|---|
| 13 | HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? | NO | 13 |
| 14 | IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW. | NO | 14 |
| 15 | PROVIDER NAME: | PROVIDER NUMBER: - V XVIII XIX | 15 |
| 16 | HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. | NO | 16 |
| 17 | HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. | NO | 17 |

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

| | | COST CENTER | SALARIES 1 | OTHER 2 | TOTAL 3 | RECLASSI-FICATIONS 4 | RECLASS. TRIAL BALANCE 5 | ADJUST-MENTS 6 | NET EXP FOR ALLOCATION 7 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | 0100 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 | 0200 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 | 0300 | NEW CAP REL COSTS-BLDG & FIXT | | 17228 | 17228 | 36318 | 53546 | -204 | 53342 | 3 |
| 4 | 0400 | NEW CAP REL COSTS-MVBLE EQUIP | | 181801 | 181801 | 14112 | 195913 | | 195913 | 4 |
| 5 | 0500 | EMPLOYEE BENEFITS | | | | 72699 | 72699 | | 72699 | 5 |
| 6 | 0600 | ADMINISTRATIVE & GENERAL | 651860 | 1900382 | 2552242 | -70481 | 2481761 | -1046960 | 1434801 | 6 |
| 7 | 0700 | MAINTENANCE & REPAIRS | | | | | | | | 7 |
| 8 | 0800 | OPERATION OF PLANT | 140610 | 170038 | 310648 | -9444 | 301204 | -315 | 300889 | 8 |
| 9 | 0900 | LAUNDRY & LINEN SERVICE | 55261 | 29387 | 84648 | | 84648 | | 84648 | 9 |
| 10 | 1000 | HOUSEKEEPING | 112976 | 35188 | 148164 | -10570 | 137594 | | 137594 | 10 |
| 11 | 1100 | DIETARY | 106071 | 115432 | 221503 | -84705 | 136798 | | 136798 | 11 |
| 12 | 1200 | CAFETERIA | | | | 82847 | 82847 | -26013 | 56834 | 12 |
| 13 | 1300 | MAINTENANCE OF PERSONNEL | | | | | | | | 13 |
| 14 | 1400 | NURSING ADMINISTRATION | | | | 78612 | 78612 | | 78612 | 14 |
| 15 | 1500 | CENTRAL SERVICES & SUPPLY | 15446 | 5488 | 20934 | -16553 | 4381 | | 4381 | 15 |
| 16 | 1600 | PHARMACY | 177692 | 199784 | 377476 | -133506 | 243970 | | 243970 | 16 |
| 17 | 1700 | MEDICAL RECORDS & LIBRARY | 260900 | 59531 | 320431 | -47834 | 272597 | -1751 | 270846 | 17 |
| 18 | 1800 | SOCIAL SERVICE | 48666 | 13208 | 61874 | | 61874 | | 61874 | 18 |
| 20 | 2000 | NONPHYSICIAN ANESTHETISTS | | | | | | | | 20 |
| 21 | 2100 | NURSING SCHOOL | | | | | | | | 21 |
| 22 | 2200 | I&R SERVICES-SALARY & FRINGES A | | | | | | | | 22 |
| 23 | 2300 | I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | 23 |
| 24 | 2400 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | 24 |
| | | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | |
| 25 | 2500 | ADULTS & PEDIATRICS | 1203095 | 448993 | 1652088 | -288309 | 1363779 | -90287 | 1273492 | 25 |
| | | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 41 | 4100 | RADIOLOGY-DIAGNOSTIC | 396836 | 319781 | 716617 | -2729 | 713888 | -113 | 713775 | 41 |
| 44 | 4400 | LABORATORY | 376213 | 669717 | 1045930 | -520 | 1045410 | -103198 | 942212 | 44 |
| 46.30 | 4650 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | 46.30 |
| 49 | 4900 | RESPIRATORY THERAPY | 178618 | 89627 | 268245 | -40595 | 227650 | -38560 | 189090 | 49 |
| 50 | 5000 | PHYSICAL THERAPY | 77069 | 71867 | 148936 | -123 | 148813 | | 148813 | 50 |
| 51 | 5100 | OCCUPATIONAL THERAPY | | | | | | | | 51 |
| 52 | 5200 | SPEECH PATHOLOGY | | | | | | | | 52 |
| 53 | 5300 | ELECTROCARDIOLOGY | 13153 | 1974 | 15127 | 28217 | 43344 | | 43344 | 53 |
| 55 | 5500 | MEDICAL SUPPLIES CHARGED TO PAT | | | | 144669 | 144669 | | 144669 | 55 |
| 56 | 5600 | DRUGS CHARGED TO PATIENTS | | | | 369959 | 369959 | | 369959 | 56 |
| | | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 | 6100 | EMERGENCY | 632413 | 180371 | 812784 | -106429 | 706355 | -208954 | 497401 | 61 |
| 62 | 6200 | OBSERVATION BEDS (NON-DISTINCT | | | | | | | | 62 |
| 63.50 | 6310 | RURAL HEALTH CLINIC | 694481 | 135666 | 830147 | 72662 | 902809 | -70 | 902739 | 63.50 |
| 63.60 | 6320 | FQHC | | | | | | | | 63.60 |
| | | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 69.10 | 6910 | CMHC | | | | | | | | 69.10 |
| 69.20 | 6920 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | 69.20 |
| 69.30 | 6930 | OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | 69.30 |
| 69.40 | 6940 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | 69.40 |
| 71 | 7100 | HOME HEALTH AGENCY | | | | | | | | 71 |
| | | SPECIAL PURPOSE COST CENTERS | | | | | | | | |
| 85.01 | 8510 | PANCREAS ACQUISITION | | | | | | | | 85.01 |
| 85.02 | 8520 | INTESTINAL ACQUISITION | | | | | | | | 85.02 |
| 85.03 | 8530 | ISLET CELL ACQUISITION | | | | | | | | 85.03 |
| 88 | 8800 | INTEREST EXPENSE | | 88297 | 88297 | -88297 | | | | 88 |
| 95 | | SUBTOTALS | 5141360 | 4733760 | 9875120 | | 9875120 | -1516425 | 8358695 | 95 |
| | | NONREIMBURSABLE COST CENTERS | | | | | | | | |
| 96 | 9600 | GIFT, FLOWER, COFFEE SHOP & CAN | | | | | | | | 96 |
| 96.01 | 9601 | VENDING MACHINE | | 15274 | 15274 | | 15274 | | 15274 | 96.01 |
| 101 | | TOTAL | 5141360 | 4749034 | 9890394 | | 9890394 | -1516425 | 8373969 | 101 |

RECLASSIFICATIONS



| | EXPLANATION OF RECLASSIFICATION ENTRY | CODE | INCREASE | | | |
|---|---|---|---|---|---|---|
| | | | COST CENTER | LINE # | SALARY | OTHER | |
| | | 1 | 2 | 3 | 4 | 5 | |
| 1 | TO RECLASS SUPPLY COST FROM CS | A | MEDICAL SUPPLIES CHARGED TO P | 55 | 11585 | 4968 | 1 |
| 2 | TO RECLASS DON COST | B | NURSING ADMINISTRATION | 14 | 70189 | 8423 | 2 |
| 3 | TO RECLASS COST TO CLINC | C | RURAL HEALTH CLINIC | 63.50 | 53570 | 7572 | 3 |
| 4 | | C | | | | | 4 |
| 5 | | C | | | | | 5 |
| 6 | TO RECLASS SUPPLY COST | D | MEDICAL SUPPLIES CHARGED TO P | 55 | | 128116 | 6 |
| 7 | | D | | | | | 7 |
| 8 | | D | | | | | 8 |
| 9 | | D | | | | | 9 |
| 10 | | D | | | | | 10 |
| 11 | | D | | | | | 11 |
| 12 | | D | | | | | 12 |
| 13 | TO RECLASS INSURANCE EXPENSE | E | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 2688 | 13 |
| 14 | | E | NEW CAP REL COSTS-MVBLE EQUIP | 4 | | 14112 | 14 |
| 15 | | E | EMPLOYEE BENEFITS | 5 | | 72699 | 15 |
| 16 | TO RECLASS INTEREST | F | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 33630 | 16 |
| 17 | | F | ADMINISTRATIVE & GENERAL | 6 | | 19018 | 17 |
| 18 | | F | RADIOLOGY-DIAGNOSTIC | 41 | | 18114 | 18 |
| 19 | | F | RESPIRATORY THERAPY | 49 | | 588 | 19 |
| 20 | | F | ADULTS & PEDIATRICS | 25 | | 5427 | 20 |
| 21 | | F | RURAL HEALTH CLINIC | 63.50 | | 11520 | 21 |
| 22 | TO RECLASS CAFE COST | G | CAFETERIA | 12 | 45611 | 37236 | 22 |
| 23 | TO RECLASS CARDIAC MONITORING COST | H | ELECTROCARDIOLOGY | 53 | 23608 | 4609 | 23 |
| 24 | | H | | | | | 24 |
| 25 | TO RECLASS DRUG COST | I | DRUGS CHARGED TO PATIENTS | 56 | | 369959 | 25 |
| 26 | | I | | | | | 26 |
| 27 | | I | | | | | 27 |
| 28 | | I | | | | | 28 |
| 29 | | I | | | | | 29 |
| 30 | | I | | | | | 30 |
| 31 | | I | | | | | 31 |
| 32 | | I | | | | | 32 |
| 33 | | I | | | | | 33 |
| 34 | | | | | | | 34 |
| 35 | | | | | | | 35 |
| 36 | TOTAL RECLASSIFICATIONS | | | | 204563 | 738679 | 36 |

RECLASSIFICATIONS



| | EXPLANATION OF RECLASSIFICATION ENTRY | CODE | DECREASE COST CENTER | LINE # | SALARY | OTHER | WKST A-7 REF. | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 6 | 7 | 8 | 9 | 10 | |
| 1 | TO RECLASS SUPPLY COST FROM CS | A | CENTRAL SERVICES & SUPPLY | 15 | 11585 | 4968 | | 1 |
| 2 | TO RECLASS DON COST | B | ADULTS & PEDIATRICS | 25 | 70189 | 8423 | | 2 |
| 3 | TO RECLASS COST TO CLINC | C | OPERATION OF PLANT | 8 | 2489 | 249 | | 3 |
| 4 | | C | HOUSEKEEPING | 10 | 9006 | 1564 | | 4 |
| 5 | | C | MEDICAL RECORDS & LIBRARY | 17 | 42075 | 5759 | | 5 |
| 6 | TO RECLASS SUPPLY COST | D | ADULTS & PEDIATRICS | 25 | | 61919 | | 6 |
| 7 | | D | EMERGENCY | 61 | | 296 | | 7 |
| 8 | | D | EMERGENCY | 61 | | 17120 | | 8 |
| 9 | | D | RADIOLOGY-DIAGNOSTIC | 41 | | 20831 | | 9 |
| 10 | | D | LABORATORY | 44 | | 519 | | 10 |
| 11 | | D | PHYSICAL THERAPY | 50 | | 4 | | 11 |
| 12 | | D | RESPIRATORY THERAPY | 49 | | 27427 | | 12 |
| 13 | TO RECLASS INSURANCE EXPENSE | E | ADMINISTRATIVE & GENERAL | 6 | | 89499 | 12 | 13 |
| 14 | | E | | | | | 12 | 14 |
| 15 | | E | | | | | | 15 |
| 16 | TO RECLASS INTEREST | F | INTEREST EXPENSE | 88 | | 88297 | 11 | 16 |
| 17 | | F | | | | | | 17 |
| 18 | | F | | | | | | 18 |
| 19 | | F | | | | | | 19 |
| 20 | | F | | | | | | 20 |
| 21 | | F | | | | | | 21 |
| 22 | TO RECLASS CAFE COST | G | DIETARY | 11 | 45611 | 37236 | | 22 |
| 23 | TO RECLASS CARDIAC MONITORING COS | H | ADULTS & PEDIATRICS | 25 | 17512 | 3999 | | 23 |
| 24 | | H | OPERATION OF PLANT | 8 | 6096 | 610 | | 24 |
| 25 | TO RECLASS DRUG COST | I | ADULTS & PEDIATRICS | 25 | | 131694 | | 25 |
| 26 | | I | PHARMACY | 16 | | 58318 | | 26 |
| 27 | | I | PHARMACY | 16 | | 75188 | | 27 |
| 28 | | I | RADIOLOGY-DIAGNOSTIC | 41 | | 12 | | 28 |
| 29 | | I | RESPIRATORY THERAPY | 49 | | 13756 | | 29 |
| 30 | | I | PHYSICAL THERAPY | 50 | | 119 | | 30 |
| 31 | | I | EMERGENCY | 61 | | 89013 | | 31 |
| 32 | | I | DIETARY | 11 | | 1858 | | 32 |
| 33 | | I | LABORATORY | 44 | | 1 | | 33 |
| 34 | | | | | | | | 34 |
| 35 | | | | | | | | 35 |
| 36 | TOTAL RECLASSIFICATIONS | | | | 204563 | 738679 | | 36 |

ANALYSIS OF CHANGES DURING COST REPORTING
PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

| | DESCRIPTION | BEGINNING BALANCES 1 | ACQUISITIONS PURCHASE 2 | ACQUISITIONS DONATION 3 | ACQUISITIONS TOTAL 4 | DISPOSALS AND RETIREMENTS 5 | ENDING BALANCE 6 | FULLY DEPRECIATED ASSETS 7 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | LAND | | | | | | | | 1 |
| 2 | LAND IMPROVEMENTS | | | | | | | | 2 |
| 3 | BUILDINGS AND FIXTURES | | | | | | | | 3 |
| 4 | BUILDING IMPROVEMENTS | | | | | | | | 4 |
| 5 | FIXED EQUIPMENT | | | | | | | | 5 |
| 6 | MOVABLE EQUIPMENT | | | | | | | | 6 |
| 7 | SUBTOTAL | | | | | | | | 7 |
| 8 | RECONCILING ITEMS | | | | | | | | 8 |
| 9 | TOTAL | | | | | | | | 9 |

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

| | DESCRIPTION | BEGINNING BALANCES 1 | ACQUISITIONS PURCHASE 2 | ACQUISITIONS DONATION 3 | ACQUISITIONS TOTAL 4 | DISPOSALS AND RETIREMENTS 5 | ENDING BALANCE 6 | FULLY DEPRECIATED ASSETS 7 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | LAND | 17000 | | | | | 17000 | | 1 |
| 2 | LAND IMPROVEMENTS | 100979 | | | | | 100979 | 100979 | 2 |
| 3 | BUILDINGS AND FIXTURES | 1209909 | | | | | 1209909 | 1077525 | 3 |
| 4 | BUILDING IMPROVEMENTS | | | | | | | | 4 |
| 5 | FIXED EQUIPMENT | | | | | | | | 5 |
| 6 | MOVABLE EQUIPMENT | 2162915 | 29752 | | 29752 | | 2192667 | 1748458 | 6 |
| 7 | SUBTOTAL | 3490803 | 29752 | | 29752 | | 3520555 | 2926962 | 7 |
| 8 | RECONCILING ITEMS | | | | | | | | 8 |
| 9 | TOTAL | 3490803 | 29752 | | 29752 | | 3520555 | 2926962 | 9 |

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

| | DESCRIPTION | COMPUTATION OF RATIOS: GROSS ASSETS | COMPUTATION OF RATIOS: CAPITALIZED LEASES | COMPUTATION OF RATIOS: GROSS ASSETS FOR RATIO | COMPUTATION OF RATIOS: RATIO | ALLOCATION OF OTHER CAPITAL: INSURANCE | ALLOCATION OF OTHER CAPITAL: TAXES | ALLOCATION OF OTHER CAPITAL: OTHER CAPITAL-RELATED COSTS | ALLOCATION OF OTHER CAPITAL: TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | .000000 | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | .000000 | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 1310888 | | 1310888 | .374159 | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 2192667 | | 2192667 | .625841 | | | | | 4 |
| 5 | TOTAL | 3503555 | | 3503555 | 1.000000 | | | | | 5 |

SUMMARY OF OLD AND NEW CAPITAL

| | DESCRIPTION | DEPRECIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 17228 | | 33426 | 2688 | | | 53342 | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 181801 | | | 14112 | | | 195913 | 4 |
| 5 | TOTAL | 199029 | | 33426 | 16800 | | | 249255 | 5 |

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

SUMMARY OF OLD AND NEW CAPITAL

| | DESCRIPTION | DEPRECIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|
| | | 9 | 10 | 11 | 12 | 13 | 14 | 15 | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 17228 | | | | | | 17228 | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 181801 | | | | | | 181801 | 4 |
| 5 | TOTAL | 199029 | | | | | | 199029 | 5 |

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

| | DESCRIPTION | BASIS 1 | AMOUNT 2 | EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3 | LINE NO. 4 | WKST A-7 REF 5 | |
|---|---|---|---|---|---|---|---|
| 1 | INVESTMENT INCOME-OLD BLDGS & FIXTURES | | | OLD CAP REL COSTS-BLDG & FIXT | 1 | | 1 |
| 2 | INVESTMENT INCOME-OLD MOVABLE EQUIPMENT | | | OLD CAP REL COSTS-MVBLE EQUIP | 2 | | 2 |
| 3 | INVESTMENT INCOME-NEW BLDGS & FIXTURES | | | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 3 |
| 4 | INVESTMENT INCOME-NEW MOVABLE EQUIPMENT | | | NEW CAP REL COSTS-MVBLE EQUIP | 4 | | 4 |
| 5 | INVESTMENT INCOME-OTHER | | | | | | 5 |
| 6 | TRADE, QUANTITY, AND TIME DISCOUNTS | | | | | | 6 |
| 7 | REFUNDS AND REBATES OF EXPENSES | B | -36864 | ADMINISTRATIVE & GENERAL | 6 | | 7 |
| 8 | RENTAL OF PROVIDER SPACE BY SUPPLIERS | | | | | | 8 |
| 9 | TELEPHONE SERVICES (PAY STATIONS EXCL) | A | -2035 | ADMINISTRATIVE & GENERAL | 6 | | 9 |
| 10 | TELEVISION AND RADIO SERVICE | | | | | | 10 |
| 11 | PARKING LOT | | | | | | 11 |
| 12 | PROVIDER-BASED PHYSICIAN ADJUSTMENT | WKST A-8-2 | -440967 | | | | 12 |
| 13 | SALE OF SCRAP, WASTE, ETC. | | | | | | 13 |
| 14 | RELATED ORGANIZATION TRANSACTIONS | WKST A-8-1 | | | | | 14 |
| 15 | LAUNDRY AND LINEN SERVICE | | | | | | 15 |
| 16 | CAFETERIA - EMPLOYEES AND GUESTS | B | -26013 | CAFETERIA | 12 | | 16 |
| 17 | RENTAL OF QUARTERS TO EMPLOYEES & OTHERS | | | | | | 17 |
| 18 | SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS | | | | | | 18 |
| 19 | SALE OF DRUGS TO OTHER THAN PATIENTS | | | | | | 19 |
| 20 | SALE OF MEDICAL RECORDS AND ABSTRACTS | A | -1751 | MEDICAL RECORDS & LIBRARY | 17 | | 20 |
| 21 | NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.) | | | | | | 21 |
| 22 | VENDING MACHINES | | | | | | 22 |
| 23 | INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES | | | | | | 23 |
| 24 | INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT | | | | | | 24 |
| 25 | ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST A-8-4 | | RESPIRATORY THERAPY | 49 | | 25 |
| 26 | ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST A-8-4 | | PHYSICAL THERAPY | 50 | | 26 |
| 27 | ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION | WKST A-8-3 | | HOME HEALTH AGENCY | 71 | | 27 |
| 28 | UTIL REVIEW-PHYSICIANS' COMPENSATION | | | UTILIZATION REVIEW-SNF | 89 | | 28 |
| 29 | DEPRECIATION--OLD BUILDINGS & FIXTURES | | | OLD CAP REL COSTS-BLDG & FIXT | 1 | | 29 |
| 30 | DEPRECIATION--OLD MOVABLE EQUIPMENT | | | OLD CAP REL COSTS-MVBLE EQUIP | 2 | | 30 |
| 31 | DEPRECIATION--NEW BUILDINGS & FIXTURES | | | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 31 |
| 32 | DEPRECIATION--NEW MOVABLE EQUIPMENT | | | NEW CAP REL COSTS-MVBLE EQUIP | 4 | | 32 |
| 33 | NON-PHYSICIAN ANESTHETIST | | | NONPHYSICIAN ANESTHETISTS | 20 | | 33 |
| 34 | PHYSICIANS' ASSISTANT | | | | | | 34 |
| 35 | ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST WKST A-8-4 | | OCCUPATIONAL THERAPY | 51 | | 35 |
| 36 | ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST WKST A-8-4 | | SPEECH PATHOLOGY | 52 | | 36 |
| 37 | INTEREST INCOME | B | -204 | NEW CAP REL COSTS-BLDG & FIXT | 3 | 11 | 37 |
| 38 | INTEREST INCOME | B | -118 | ADMINISTRATIVE & GENERAL | 6 | | 38 |
| 39 | INTEREST INCOME | B | -113 | RADIOLOGY-DIAGNOSTIC | 41 | | 39 |
| 40 | INTEREST INCOME | B | -32 | ADULTS & PEDIATRICS | 25 | | 40 |
| 41 | INTEREST INCOME | B | -70 | RURAL HEALTH CLINIC | 63.50 | | 41 |
| 42 | CONTRIBUTIONS & DONATIONS | A | -8352 | ADMINISTRATIVE & GENERAL | 6 | | 42 |
| 43 | BAD DEBT | A | -889044 | ADMINISTRATIVE & GENERAL | 6 | | 43 |
| 44 | LATE FEES | A | -10362 | ADMINISTRATIVE & GENERAL | 6 | | 44 |
| 45 | RECRUITING FEES | A | -19 | ADMINISTRATIVE & GENERAL | 6 | | 45 |
| 46 | PROVIDER TAX | A | -95206 | ADMINISTRATIVE & GENERAL | 6 | | 46 |
| 47 | LOBBING PORTION OF DUES | A | -4960 | ADMINISTRATIVE & GENERAL | 6 | | 47 |
| 48 | RENTAL COST | A | -315 | OPERATION OF PLANT | 8 | | 48 |
| 49 | | | | | | | 49 |
| 50 | TOTAL | | -1516425 | | | | 50 |

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

| | WKST A LINE NO. | COST CENTER/ PHYSICIAN IDENTIFIER | | TOTAL REMUNERATION INCL FRINGES | PROFESSIONAL COMPONENT | PROVIDER COMPONENT | RCE AMOUNT | PHYSICIAN/ PROVIDER COMPONENT HOURS | UNADJUSTED RCE LIMIT | PERCENT OF UNADJUSTED RCE LIMIT |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1 | 6 | ADMINISTRATIVE & GENERAL | MED STAFF DIRECTOR | 30085 | | 30085 | | | | |
| 2 | 25 | ADULTS & PEDIATRICS | AGGREGATE | 90255 | 90255 | | | | | |
| 3 | 44 | LABORATORY | AGGREGATE | 109298 | 103198 | 6100 | | | | |
| 4 | 49 | RESPIRATORY THERAPY | AGGREGATE | 38560 | 38560 | | | | | |
| 5 | 61 | EMERGENCY | AGGREGATE | 453263 | 208954 | 244309 | | | | |
| 101 | | TOTAL | | 721461 | 440967 | 280494 | | | | |

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

| | WKST A LINE NO. 10 | COST CENTER/ PHYSICIAN IDENTIFIER 11 | | COST OF MEMBERSHIP & CONTIN. EDUCATION 12 | PROVIDER COMPONENT SHARE OF COLUMN 12 13 | PHYSICIAN COST OF MALPRACTICE INSURANCE 14 | PROVIDER COMPONENT SHARE OF COLUMN 14 15 | ADJUSTED RCE LIMIT 16 | RCE DIS- ALLOWANCE 17 | ADJUST- MENT 18 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 6 | ADMINISTRATIVE & GENERAL | MED STAFF DIRECTOR | | | | | | | |
| 2 | 25 | ADULTS & PEDIATRICS | AGGREGATE | | | | | | | 90255 |
| 3 | 44 | LABORATORY | AGGREGATE | | | | | | | 103198 |
| 4 | 49 | RESPIRATORY THERAPY | AGGREGATE | | | | | | | 38560 |
| 5 | 61 | EMERGENCY | AGGREGATE | | | | | | | 208954 |
| 101 | | TOTAL | | | | | | | | 440967 |

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2008.05
08/20/2008 09:19

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

| | | | |
|---|---|---|---|
| 1 | TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) | 52 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | 780 | 2 |
| 3 | NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE | | 3 |
| 4 | NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE | | 4 |
| 5 | NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS | | 5 |
| 6 | NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS | | 6 |
| 7 | STANDARD TRAVEL EXPENSE RATE | 3.55 | 7 |
| 8 | OPTIONAL TRAVEL EXPENSE RATE PER MILE | | 8 |

| | | SUPERVISORS 1 | THERAPISTS 2 | ASSISTANTS 3 | AIDES 4 | TRAINEES 5 | |
|---|---|---|---|---|---|---|---|
| 9 | TOTAL HOURS WORKED | | 467.00 | | | | 9 |
| 10 | AHSEA | 80.13 | 59.67 | 44.75 | 29.68 | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 29.84 | 29.84 | 22.38 | | | 11 |
| 12 | NO OF TRAVEL HRS (PROV SITE) | | | | | | 12 |
| 12.01 | NO OF TRAVEL HRS (OFFSITE) | | | | | | 12.01 |
| 13 | MILES DRIVEN (PROV SITE) | | | | | | 13 |
| 13.01 | MILES DRIVEN (OFFSITE) | | | | | | 13.01 |

PART II - SALARY EQUIVALENCY COMPUTATION

| | | | |
|---|---|---|---|
| 14 | SUPERVISORS | | 14 |
| 15 | THERAPISTS | 27866 | 15 |
| 16 | ASSISTANTS | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | 27866 | 17 |
| 18 | AIDES | | 18 |
| 19 | TRAINEES | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | 27866 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | 59.67 | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | 46543 | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | 46543 | 23 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998



[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

| | | |
|---|---|---|
| | STANDARD TRAVEL ALLOWANCE | |
| 24 | THERAPISTS | 24 |
| 25 | ASSISTANTS | 25 |
| 26 | SUBTOTAL | 26 |
| 27 | STANDARD TRAVEL EXPENSE | 27 |
| 28 | TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE | 28 |
| | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | |
| 29 | THERAPISTS | 29 |
| 30 | ASSISTANTS | 30 |
| 31 | SUBTOTAL | 31 |
| 32 | OPTIONAL TRAVEL EXPENSE | 32 |
| 33 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 33 |
| 34 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 34 |
| 35 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | 35 |

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

| | | |
|---|---|---|
| | STANDARD TRAVEL EXPENSE | |
| 36 | THERAPISTS | 36 |
| 37 | ASSISTANTS | 37 |
| 38 | SUBTOTAL | 38 |
| 39 | STANDARD TRAVEL EXPENSE | 39 |
| | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | |
| 40 | THERAPISTS | 40 |
| 41 | ASSISTANTS | 41 |
| 42 | SUBTOTAL | 42 |
| 43 | OPTIONAL TRAVEL EXPENSE | 43 |
| | TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES | |
| 44 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 44 |
| 45 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 45 |
| 46 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | 46 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

| | | THERAPISTS 1 | ASSISTANTS 2 | AIDES 3 | TRAINEES 4 | TOTAL 5 | |
|---|---|---|---|---|---|---|---|
| 47 | OVERTIME HOURS WORKED DURING REPORTING PERIOD | | | | | | 47 |
| 48 | OVERTIME RATE | | | | | | 48 |
| 49 | TOTAL OVERTIME | | | | | | 49 |
| | CALCULATION OF LIMIT | | | | | | |
| 50 | PERCENTAGE OF OVERTIME HOURS BY CATEGORY | | | | | | 50 |
| 51 | ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50 | | | | | | 51 |
| | DETERMINATION OF OVERTIME ALLOWANCE | | | | | | |
| 52 | ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT | | | | | | 52 |
| 53 | OVERTIME COST LIMITATION | | | | | | 53 |
| 54 | MAXIMUM OVERTIME COST | | | | | | 54 |
| 55 | PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA | | | | | | 55 |
| 56 | OVERTIME ALLOWANCE | | | | | | 56 |

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

| | | | |
|---|---|---|---|
| 57 | SALARY EQUIVALENCY AMOUNT | 46543 | 57 |
| 58 | TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE | | 58 |
| 59 | TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES | | 59 |
| 60 | OVERTIME ALLOWANCE | | 60 |
| 61 | EQUIPMENT COST | | 61 |
| 62 | SUPPLIES | | 62 |
| 63 | TOTAL ALLOWANCE | 46543 | 63 |
| 64 | TOTAL COST OF OUTSIDE SUPPLIER SERVICES | 27994 | 64 |
| 65 | EXCESS OVER LIMITATION | | 65 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ XX ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

| | | | |
|---|---|---|---|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 27994 | 66 |
| 67 | TOTAL COST | 27994 | 67 |
| 68 | RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL | 1.000000 | 68 |
| 69 | EXCESS OF COST OVER LIMITATION - HOSPITAL | 0 | 69 |
| 70 | TOTAL EXCESS OF COST OVER LIMITATION | 0 | 70 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

| | | | |
|---|---|---|---|
| 1 | TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) | 52 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | 780 | 2 |
| 3 | NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE | | 3 |
| 4 | NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE | | 4 |
| 5 | NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS | | 5 |
| 6 | NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS | | 6 |
| 7 | STANDARD TRAVEL EXPENSE RATE | | 7 |
| 8 | OPTIONAL TRAVEL EXPENSE RATE PER MILE | | 8 |

| | | SUPERVISORS 1 | THERAPISTS 2 | ASSISTANTS 3 | AIDES 4 | TRAINEES 5 | |
|---|---|---|---|---|---|---|---|
| 9 | TOTAL HOURS WORKED | | 332.00 | | | | 9 |
| 10 | AHSEA | 84.54 | 62.96 | 47.22 | 31.31 | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 31.48 | 31.48 | 23.61 | | | 11 |
| 12 | NO OF TRAVEL HRS (PROV SITE) | | | | | | 12 |
| 12.01 | NO OF TRAVEL HRS (OFFSITE) | | | | | | 12.01 |
| 13 | MILES DRIVEN (PROV SITE) | | | | | | 13 |
| 13.01 | MILES DRIVEN (OFFSITE) | | | | | | 13.01 |

PART II - SALARY EQUIVALENCY COMPUTATION

| | | | |
|---|---|---|---|
| 14 | SUPERVISORS | | 14 |
| 15 | THERAPISTS | 20903 | 15 |
| 16 | ASSISTANTS | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | 20903 | 17 |
| 18 | AIDES | | 18 |
| 19 | TRAINEES | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | 20903 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | 62.96 | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | 49109 | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | 49109 | 23 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

| | | |
|---|---|---|
| | STANDARD TRAVEL ALLOWANCE | |
| 24 | THERAPISTS | 24 |
| 25 | ASSISTANTS | 25 |
| 26 | SUBTOTAL | 26 |
| 27 | STANDARD TRAVEL EXPENSE | 27 |
| 28 | TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE | 28 |
| | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | |
| 29 | THERAPISTS | 29 |
| 30 | ASSISTANTS | 30 |
| 31 | SUBTOTAL | 31 |
| 32 | OPTIONAL TRAVEL EXPENSE | 32 |
| 33 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 33 |
| 34 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 34 |
| 35 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | 35 |

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

| | | |
|---|---|---|
| | STANDARD TRAVEL EXPENSE | |
| 36 | THERAPISTS | 36 |
| 37 | ASSISTANTS | 37 |
| 38 | SUBTOTAL | 38 |
| 39 | STANDARD TRAVEL EXPENSE | 39 |
| | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | |
| 40 | THERAPISTS | 40 |
| 41 | ASSISTANTS | 41 |
| 42 | SUBTOTAL | 42 |
| 43 | OPTIONAL TRAVEL EXPENSE | 43 |
| | TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES | |
| 44 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 44 |
| 45 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 45 |
| 46 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | 46 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

| | | THERAPISTS 1 | ASSISTANTS 2 | AIDES 3 | TRAINEES 4 | TOTAL 5 | |
|---|---|---|---|---|---|---|---|
| 47 | OVERTIME HOURS WORKED DURING REPORTING PERIOD | | | | | | 47 |
| 48 | OVERTIME RATE | | | | | | 48 |
| 49 | TOTAL OVERTIME | | | | | | 49 |
| | CALCULATION OF LIMIT | | | | | | |
| 50 | PERCENTAGE OF OVERTIME HOURS BY CATEGORY | | | | | | 50 |
| 51 | ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50 | | | | | | 51 |
| | DETERMINATION OF OVERTIME ALLOWANCE | | | | | | |
| 52 | ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT | | | | | | 52 |
| 53 | OVERTIME COST LIMITATION | | | | | | 53 |
| 54 | MAXIMUM OVERTIME COST | | | | | | 54 |
| 55 | PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA | | | | | | 55 |
| 56 | OVERTIME ALLOWANCE | | | | | | 56 |

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

| | | | |
|---|---|---|---|
| 57 | SALARY EQUIVALENCY AMOUNT | 49109 | 57 |
| 58 | TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE | | 58 |
| 59 | TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES | | 59 |
| 60 | OVERTIME ALLOWANCE | | 60 |
| 61 | EQUIPMENT COST | | 61 |
| 62 | SUPPLIES | | 62 |
| 63 | TOTAL ALLOWANCE | 49109 | 63 |
| 64 | TOTAL COST OF OUTSIDE SUPPLIER SERVICES | 19898 | 64 |
| 65 | EXCESS OVER LIMITATION | | 65 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ ] OCCUPATIONAL [ XX ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

| | | | |
|---|---|---|---|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 19898 | 66 |
| 67 | TOTAL COST | 19898 | 67 |
| 68 | RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL | 1.000000 | 68 |
| 69 | EXCESS OF COST OVER LIMITATION - HOSPITAL | 0 | 69 |
| 70 | TOTAL EXCESS OF COST OVER LIMITATION | 0 | 70 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

| | | | |
|---|---|---|---|
| 1 | TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) | 45 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | 675 | 2 |
| 3 | NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE | | 3 |
| 4 | NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE | | 4 |
| 5 | NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS | | 5 |
| 6 | NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS | | 6 |
| 7 | STANDARD TRAVEL EXPENSE RATE | | 7 |
| 8 | OPTIONAL TRAVEL EXPENSE RATE PER MILE | | 8 |

| | | SUPERVISORS 1 | THERAPISTS 2 | ASSISTANTS 3 | AIDES 4 | TRAINEES 5 | |
|---|---|---|---|---|---|---|---|
| 9 | TOTAL HOURS WORKED | | 78.00 | | | | 9 |
| 10 | AHSEA | 77.00 | 57.33 | 43.00 | 28.52 | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 28.67 | 28.67 | 21.50 | | | 11 |
| 12 | NO OF TRAVEL HRS (PROV SITE) | | | | | | 12 |
| 12.01 | NO OF TRAVEL HRS (OFFSITE) | | | | | | 12.01 |
| 13 | MILES DRIVEN (PROV SITE) | | | | | | 13 |
| 13.01 | MILES DRIVEN (OFFSITE) | | | | | | 13.01 |

PART II - SALARY EQUIVALENCY COMPUTATION

| | | | |
|---|---|---|---|
| 14 | SUPERVISORS | | 14 |
| 15 | THERAPISTS | 4472 | 15 |
| 16 | ASSISTANTS | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | 4472 | 17 |
| 18 | AIDES | | 18 |
| 19 | TRAINEES | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | 4472 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | 57.33 | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | 38698 | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | 38698 | 23 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998



[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

| | | |
|---|---|---|
| | STANDARD TRAVEL ALLOWANCE | |
| 24 | THERAPISTS | 24 |
| 25 | ASSISTANTS | 25 |
| 26 | SUBTOTAL | 26 |
| 27 | STANDARD TRAVEL EXPENSE | 27 |
| 28 | TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE | 28 |
| | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | |
| 29 | THERAPISTS | 29 |
| 30 | ASSISTANTS | 30 |
| 31 | SUBTOTAL | 31 |
| 32 | OPTIONAL TRAVEL EXPENSE | 32 |
| 33 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 33 |
| 34 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 34 |
| 35 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | 35 |

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

| | | |
|---|---|---|
| | STANDARD TRAVEL EXPENSE | |
| 36 | THERAPISTS | 36 |
| 37 | ASSISTANTS | 37 |
| 38 | SUBTOTAL | 38 |
| 39 | STANDARD TRAVEL EXPENSE | 39 |
| | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | |
| 40 | THERAPISTS | 40 |
| 41 | ASSISTANTS | 41 |
| 42 | SUBTOTAL | 42 |
| 43 | OPTIONAL TRAVEL EXPENSE | 43 |
| | TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES | |
| 44 | STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 44 |
| 45 | OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE | 45 |
| 46 | OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE | 46 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

| | | THERAPISTS 1 | ASSISTANTS 2 | AIDES 3 | TRAINEES 4 | TOTAL 5 | |
|---|---|---|---|---|---|---|---|
| 47 | OVERTIME HOURS WORKED DURING REPORTING PERIOD | | | | | | 47 |
| 48 | OVERTIME RATE | | | | | | 48 |
| 49 | TOTAL OVERTIME CALCULATION OF LIMIT | | | | | | 49 |
| 50 | PERCENTAGE OF OVERTIME HOURS BY CATEGORY | | | | | | 50 |
| 51 | ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50 | | | | | | 51 |
| 52 | DETERMINATION OF OVERTIME ALLOWANCE ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT | | | | | | 52 |
| 53 | OVERTIME COST LIMITATION | | | | | | 53 |
| 54 | MAXIMUM OVERTIME COST | | | | | | 54 |
| 55 | PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA | | | | | | 55 |
| 56 | OVERTIME ALLOWANCE | | | | | | 56 |

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

| | | | |
|---|---|---|---|
| 57 | SALARY EQUIVALENCY AMOUNT | 38698 | 57 |
| 58 | TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE | | 58 |
| 59 | TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES | | 59 |
| 60 | OVERTIME ALLOWANCE | | 60 |
| 61 | EQUIPMENT COST | | 61 |
| 62 | SUPPLIES | | 62 |
| 63 | TOTAL ALLOWANCE | 38698 | 63 |
| 64 | TOTAL COST OF OUTSIDE SUPPLIER SERVICES | 4662 | 64 |
| 65 | EXCESS OVER LIMITATION | | 65 |

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ XX ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

| | | | |
|---|---|---|---|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 4662 | 66 |
| 67 | TOTAL COST | 4662 | 67 |
| 68 | RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL | 1.000000 | 68 |
| 69 | EXCESS OF COST OVER LIMITATION - HOSPITAL | 0 | 69 |
| 70 | TOTAL EXCESS OF COST OVER LIMITATION | 0 | 70 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

| | COST CENTER DESCRIPTION | NET EXP FOR COST ALLOCATION 0 | NEW CAP BLDGS & FIXTURES 3 | NEW CAP MOVABLE EQUIPMENT 4 | EMPLOYEE BENEFITS 5 | SUBTOTAL 5A | ADMINIS-TRATIVE & GENERAL 6 | OPERATION OF PLANT 8 | LAUNDRY & LINEN SERVICE 9 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 53342 | 53342 | | | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 195913 | | 195913 | | | | | | 4 |
| 5 | EMPLOYEE BENEFITS | 72699 | | | 72699 | | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | 1434801 | 8689 | 32038 | 9223 | 1484751 | 1484751 | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 | OPERATION OF PLANT | 300889 | 5288 | 19499 | 1868 | 327544 | 70592 | 398136 | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | 84648 | 2384 | 8792 | 782 | 96606 | 20820 | 24117 | 141543 | 9 |
| 10 | HOUSEKEEPING | 137594 | 83 | 305 | 1471 | 139453 | 30055 | 837 | 4731 | 10 |
| 11 | DIETARY | 136798 | 2430 | 8960 | 855 | 149043 | 32121 | 24577 | 5155 | 11 |
| 12 | CAFETERIA | 56834 | 994 | 3663 | 645 | 62136 | 13391 | 10049 | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 | NURSING ADMINISTRATION | 78612 | 4941 | 18217 | 993 | 102763 | 22147 | 49971 | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | 4381 | | | 55 | 4436 | 956 | | | 15 |
| 16 | PHARMACY | 243970 | 1043 | 3846 | 2514 | 251373 | 54175 | 10551 | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | 270846 | 2310 | 8517 | 3096 | 284769 | 61373 | 23363 | | 17 |
| 18 | SOCIAL SERVICE | 61874 | 455 | 1679 | 689 | 64697 | 13943 | 4606 | | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | | | | | | 20 |
| 21 | NURSING SCHOOL | | | | | | | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | | | | | | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 | ADULTS & PEDIATRICS | 1273492 | 11351 | 41845 | 15737 | 1342425 | 289319 | 114785 | 109709 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 713775 | 3657 | 13485 | 5615 | 736532 | 158736 | 36992 | 3065 | 41 |
| 44 | LABORATORY | 942212 | 1407 | 5190 | 5323 | 954132 | 205633 | 14236 | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 189090 | 1043 | 3846 | 2527 | 196506 | 42351 | 10551 | | 49 |
| 50 | PHYSICAL THERAPY | 148813 | 2028 | 7479 | 1090 | 159410 | 34356 | 20516 | 11002 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 43344 | 522 | 1923 | 520 | 46309 | 9980 | 5276 | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | 144669 | 1101 | 4060 | 164 | 149994 | 32326 | 11137 | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 369959 | | | | 369959 | 79733 | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 | EMERGENCY | 497401 | 2714 | 10005 | 8948 | 519068 | 111868 | 27445 | 7881 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | 902739 | | | 10584 | 913323 | 196838 | | | 63.50 |
| 63.60 | FQHC | | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 | CMHC | | | | | | | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | | | | | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 | PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 | SUBTOTALS | 8358695 | 52440 | 193349 | 72699 | 8355229 | 1480713 | 389009 | 141543 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & CAN | | 695 | 2564 | | 3259 | 702 | 7034 | | 96 |
| 96.01 | VENDING MACHINE | 15274 | 207 | | | 15481 | 3336 | 2093 | | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 | TOTAL | 8373969 | 53342 | 195913 | 72699 | 8373969 | 1484751 | 398136 | 141543 | 103 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

| | COST CENTER DESCRIPTION | HOUSE-KEEPING | DIETARY | CAFETERIA | NURSING ADMINIS-TRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 10 | 11 | 12 | 14 | 15 | 16 | 17 | 18 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 4 |
| 5 | EMPLOYEE BENEFITS | | | | | | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | | | | | | | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 | OPERATION OF PLANT | | | | | | | | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | | | | | | | | | 9 |
| 10 | HOUSEKEEPING | 175076 | | | | | | | | 10 |
| 11 | DIETARY | 11530 | 222426 | | | | | | | 11 |
| 12 | CAFETERIA | 4714 | 95496 | 185786 | | | | | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 | NURSING ADMINISTRATION | 23444 | | 3131 | 201456 | | | | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | | 248 | 5635 | 11275 | | | | 15 |
| 16 | PHARMACY | 4950 | | 5652 | | 604 | 327305 | | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | 10961 | | 15123 | | 149 | | 395738 | | 17 |
| 18 | SOCIAL SERVICE | 2161 | | 1528 | | 21 | | | 86956 | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | | | | | | 20 |
| 21 | NURSING SCHOOL | | | | | | | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | | | | | | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 | ADULTS & PEDIATRICS | 53850 | 126930 | 63754 | 195821 | 1254 | | 254922 | 86956 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 17354 | | 19132 | | 328 | | 34118 | | 41 |
| 44 | LABORATORY | 6679 | | 17204 | | 6155 | | 14635 | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 4950 | | 8554 | | 126 | | | | 49 |
| 50 | PHYSICAL THERAPY | 9625 | | 4373 | | 140 | | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 2475 | | 859 | | | | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | 5225 | | 783 | | 2094 | | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | | | | | | 315817 | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 | EMERGENCY | 12876 | | 14512 | | 135 | | 2424 | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | | 30933 | | 269 | 11488 | 89639 | | 63.50 |
| 63.60 | FQHC | | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 | CMHC | | | | | | | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | | | | | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 | PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 | SUBTOTALS | 170794 | 222426 | 185786 | 201456 | 11275 | 327305 | 395738 | 86956 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & CAN | 3300 | | | | | | | | 96 |
| 96.01 | VENDING MACHINE | 982 | | | | | | | | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 | TOTAL | 175076 | 222426 | 185786 | 201456 | 11275 | 327305 | 395738 | 86956 | 103 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

| | COST CENTER DESCRIPTION | SUBTOTAL | I&R COST & POST STEP-DOWN ADJS | TOTAL | |
|---|---|---|---|---|---|
| | | 25 | 26 | 27 | |
| | GENERAL SERVICE COST CENTERS | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | | 4 |
| 5 | EMPLOYEE BENEFITS | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | | 7 |
| 8 | OPERATION OF PLANT | | | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | | | | 9 |
| 10 | HOUSEKEEPING | | | | 10 |
| 11 | DIETARY | | | | 11 |
| 12 | CAFETERIA | | | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | | 13 |
| 14 | NURSING ADMINISTRATION | | | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | | | 15 |
| 16 | PHARMACY | | | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | | | | 17 |
| 18 | SOCIAL SERVICE | | | | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | 20 |
| 21 | NURSING SCHOOL | | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | |
| 25 | ADULTS & PEDIATRICS | 2639725 | | 2639725 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 1006257 | | 1006257 | 41 |
| 44 | LABORATORY | 1218674 | | 1218674 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 263038 | | 263038 | 49 |
| 50 | PHYSICAL THERAPY | 239422 | | 239422 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 64899 | | 64899 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | 201559 | | 201559 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 765509 | | 765509 | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 | EMERGENCY | 696209 | | 696209 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | 1242490 | | 1242490 | 63.50 |
| 63.60 | FQHC | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| 69.10 | CMHC | | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | | |
| 85.01 | PANCREAS ACQUISITION | | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | | 85.03 |
| 95 | SUBTOTALS | 8337782 | | 8337782 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & CAN | 14295 | | 14295 | 96 |
| 96.01 | VENDING MACHINE | 21892 | | 21892 | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | 102 |
| 103 | TOTAL | 8373969 | | 8373969 | 103 |

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2008.05
08/20/2008 09:19

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

| | COST CENTER DESCRIPTION | DIR ASSGND CAP-REL COSTS 0 | NEW CAP BLDGS & FIXTURES 3 | NEW CAP MOVABLE EQUIPMENT 4 | CAP REL COST TO BE ALLOC 4A | ADMINIS-TRATIVE & GENERAL 6 | OPERATION OF PLANT 8 | LAUNDRY & LINEN SERVICE 9 | HOUSE-KEEPING 10 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | GENERAL SERVICE COST CENTERS | | | | | | | | | 1 |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 2 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 3 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 4 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 5 |
| 5 | EMPLOYEE BENEFITS | | | | | | | | | 6 |
| 6 | ADMINISTRATIVE & GENERAL | | 8689 | 32038 | 40727 | 40727 | | | | 7 |
| 7 | MAINTENANCE & REPAIRS | | | | | | | | | 8 |
| 8 | OPERATION OF PLANT | | 5288 | 19499 | 24787 | 1936 | 26723 | | | 9 |
| 9 | LAUNDRY & LINEN SERVICE | | 2384 | 8792 | 11176 | 571 | 1619 | 13366 | | 10 |
| 10 | HOUSEKEEPING | | 83 | 305 | 388 | 824 | 56 | 447 | 1715 | 11 |
| 11 | DIETARY | | 2430 | 8960 | 11390 | 881 | 1650 | 487 | 113 | 12 |
| 12 | CAFETERIA | | 994 | 3663 | 4657 | 367 | 674 | | 46 | 13 |
| 13 | MAINTENANCE OF PERSONNEL | | | | | | | | | 14 |
| 14 | NURSING ADMINISTRATION | | 4941 | 18217 | 23158 | 608 | 3354 | | 230 | 15 |
| 15 | CENTRAL SERVICES & SUPPLY | | | | | 26 | | | | 16 |
| 16 | PHARMACY | | 1043 | 3846 | 4889 | 1486 | 708 | | 48 | 17 |
| 17 | MEDICAL RECORDS & LIBRARY | | 2310 | 8517 | 10827 | 1684 | 1568 | | 107 | 18 |
| 18 | SOCIAL SERVICE | | 455 | 1679 | 2134 | 382 | 309 | | 21 | 20 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | | | | | | 21 |
| 21 | NURSING SCHOOL | | | | | | | | | 22 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | | | | | | | | 23 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | | 24 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | | |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | 25 |
| 25 | ADULTS & PEDIATRICS | | 11351 | 41845 | 53196 | 7935 | 7705 | 10360 | 530 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | 41 |
| 41 | RADIOLOGY-DIAGNOSTIC | | 3657 | 13485 | 17142 | 4354 | 2483 | 289 | 170 | 44 |
| 44 | LABORATORY | | 1407 | 5190 | 6597 | 5641 | 955 | | 65 | 46.30 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 49 |
| 49 | RESPIRATORY THERAPY | | 1043 | 3846 | 4889 | 1162 | 708 | | 48 | 50 |
| 50 | PHYSICAL THERAPY | | 2028 | 7479 | 9507 | 942 | 1377 | 1039 | 94 | 51 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | | 52 |
| 52 | SPEECH PATHOLOGY | | | | | | | | | 53 |
| 53 | ELECTROCARDIOLOGY | | 522 | 1923 | 2445 | 274 | 354 | | 24 | 55 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | | 1101 | 4060 | 5161 | 887 | 748 | | 51 | 56 |
| 56 | DRUGS CHARGED TO PATIENTS | | | | | 2187 | | | | |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | 61 |
| 61 | EMERGENCY | | 2714 | 10005 | 12719 | 3069 | 1842 | 744 | 126 | 62 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 63.50 |
| 63.50 | RURAL HEALTH CLINIC | | | | | 5400 | | | | 63.60 |
| 63.60 | FQHC | | | | | | | | | |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | 69.10 |
| 69.10 | CMHC | | | | | | | | | 69.20 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.30 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.40 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 71 |
| 71 | HOME HEALTH AGENCY | | | | | | | | | |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | 85.01 |
| 85.01 | PANCREAS ACQUISITION | | | | | | | | | 85.02 |
| 85.02 | INTESTINAL ACQUISITION | | | | | | | | | 85.03 |
| 85.03 | ISLET CELL ACQUISITION | | | | | | | | | 95 |
| 95 | SUBTOTALS | | 52440 | 193349 | 245789 | 40616 | 26110 | 13366 | 1673 | |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | 96 |
| 96 | GIFT, FLOWER, COFFEE SHOP & CAN | | 695 | 2564 | 3259 | 19 | 472 | | 32 | 96.01 |
| 96.01 | VENDING MACHINE | | 207 | | 207 | 92 | 141 | | 10 | 101 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | | | 102 |
| 102 | NEGATIVE COST CENTER | | | | | | | | | 103 |
| 103 | TOTAL | | 53342 | 195913 | 249255 | 40727 | 26723 | 13366 | 1715 | |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

| | COST CENTER DESCRIPTION | DIETARY | CAFETERIA | NURSING ADMINIS-TRATION | CENTRAL SERVICES & SUPPLY | PHARMACY | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | SUBTOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | 11 | 12 | 14 | 15 | 16 | 17 | 18 | 25 | |
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 4 |
| 5 | EMPLOYEE BENEFITS | | | | | | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | | | | | | | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 | OPERATION OF PLANT | | | | | | | | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | | | | | | | | | 9 |
| 10 | HOUSEKEEPING | | | | | | | | | 10 |
| 11 | DIETARY | 14521 | | | | | | | | 11 |
| 12 | CAFETERIA | 6234 | 11978 | | | | | | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 | NURSING ADMINISTRATION | | 202 | 27552 | | | | | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | 16 | 771 | 813 | | | | | 15 |
| 16 | PHARMACY | | 364 | | 44 | 7539 | | | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | | 975 | | 11 | | 15172 | | | 17 |
| 18 | SOCIAL SERVICE | | 98 | | 2 | | | 2946 | | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | | | | | | 20 |
| 21 | NURSING SCHOOL | | | | | | | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | | | | | | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | | | | | | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 | ADULTS & PEDIATRICS | 8287 | 4111 | 26781 | 90 | | 9773 | 2946 | 131714 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | | 1234 | | 24 | | 1308 | | 27004 | 41 |
| 44 | LABORATORY | | 1109 | | 443 | | 561 | | 15371 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | | 552 | | 9 | | | | 7368 | 49 |
| 50 | PHYSICAL THERAPY | | 282 | | 10 | | | | 13251 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | | 55 | | | | | | 3152 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | | 50 | | 151 | | | | 7048 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | | | | | 7274 | | | 9461 | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 | EMERGENCY | | 936 | | 10 | | 93 | | 19539 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | 1994 | | 19 | 265 | 3437 | | 11115 | 63.50 |
| 63.60 | FQHC | | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 | CMHC | | | | | | | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | | | | | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 | PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 | SUBTOTALS | 14521 | 11978 | 27552 | 813 | 7539 | 15172 | 2946 | 245023 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & CAN | | | | | | | | 3782 | 96 |
| 96.01 | VENDING MACHINE | | | | | | | | 450 | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 | TOTAL | 14521 | 11978 | 27552 | 813 | 7539 | 15172 | 2946 | 249255 | 103 |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

| | COST CENTER DESCRIPTION | I&R COST & POST STEP-DOWN ADJS 26 | TOTAL 27 | |
|---|---|---|---|---|
| | GENERAL SERVICE COST CENTERS | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | 4 |
| 5 | EMPLOYEE BENEFITS | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | 7 |
| 8 | OPERATION OF PLANT | | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | | | 9 |
| 10 | HOUSEKEEPING | | | 10 |
| 11 | DIETARY | | | 11 |
| 12 | CAFETERIA | | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | 13 |
| 14 | NURSING ADMINISTRATION | | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | | 15 |
| 16 | PHARMACY | | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | | | 17 |
| 18 | SOCIAL SERVICE | | | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | 20 |
| 21 | NURSING SCHOOL | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES A | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS A | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | |
| 25 | ADULTS & PEDIATRICS | | 131714 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | | 27004 | 41 |
| 44 | LABORATORY | | 15371 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | 46.30 |
| 49 | RESPIRATORY THERAPY | | 7368 | 49 |
| 50 | PHYSICAL THERAPY | | 13251 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | 51 |
| 52 | SPEECH PATHOLOGY | | | 52 |
| 53 | ELECTROCARDIOLOGY | | 3152 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | | 7048 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | | 9461 | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | |
| 61 | EMERGENCY | | 19539 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | 11115 | 63.50 |
| 63.60 | FQHC | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | |
| 69.10 | CMHC | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERAPY | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | |
| 85.01 | PANCREAS ACQUISITION | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | 85.03 |
| 95 | SUBTOTALS | | 245023 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & CAN | | 3782 | 96 |
| 96.01 | VENDING MACHINE | | 450 | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | 101 |
| 102 | NEGATIVE COST CENTER | | | 102 |
| 103 | TOTAL | | 249255 | 103 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | COST CENTER DESCRIPTION | NEW CAP BLDGS & FIXTURES SQUARE FEET 3 | NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4 | EMPLOYEE BENEFITS GROSS SALARIES 5 | RECONCILIATION 6A | ADMINISTRATIVE & GENERAL ACCUM COST 6 | OPERATION OF PLANT SQUARE FEET 8 | LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9 | |
|---|---|---|---|---|---|---|---|---|---|
| | GENERAL SERVICE COST CENTERS | | | | | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 25771 | | | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | 25671 | | | | | | 4 |
| 5 | EMPLOYEE BENEFITS | | | 5138063 | | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | 4198 | 4198 | 651860 | -1484751 | 6889218 | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | | | | | | 7 |
| 8 | OPERATION OF PLANT | 2555 | 2555 | 132025 | | 327544 | 19018 | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | 1152 | 1152 | 55261 | | 96606 | 1152 | 200441 | 9 |
| 10 | HOUSEKEEPING | 40 | 40 | 103970 | | 139453 | 40 | 6700 | 10 |
| 11 | DIETARY | 1174 | 1174 | 60460 | | 149043 | 1174 | 7300 | 11 |
| 12 | CAFETERIA | 480 | 480 | 45611 | | 62136 | 480 | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | | | | | | 13 |
| 14 | NURSING ADMINISTRATION | 2387 | 2387 | 70189 | | 102763 | 2387 | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | | 3861 | | 4436 | | | 15 |
| 16 | PHARMACY | 504 | 504 | 177692 | | 251373 | 504 | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | 1116 | 1116 | 218825 | | 284769 | 1116 | | 17 |
| 18 | SOCIAL SERVICE | 220 | 220 | 48666 | | 64697 | 220 | | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | | | | | 20 |
| 21 | NURSING SCHOOL | | | | | | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES | | | | | | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS | | | | | | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | |
| 25 | ADULTS & PEDIATRICS | 5483 | 5483 | 1112097 | | 1342425 | 5483 | 155361 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 1767 | 1767 | 396836 | | 736532 | 1767 | 4340 | 41 |
| 44 | LABORATORY | 680 | 680 | 376213 | | 954132 | 680 | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 504 | 504 | 178618 | | 196506 | 504 | | 49 |
| 50 | PHYSICAL THERAPY | 980 | 980 | 77069 | | 159410 | 980 | 15580 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 252 | 252 | 36761 | | 46309 | 252 | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO P | 532 | 532 | 11585 | | 149994 | 532 | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | | | | | 369959 | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 | EMERGENCY | 1311 | 1311 | 632413 | | 519068 | 1311 | 11160 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINC | | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | | 748051 | | 913323 | | | 63.50 |
| 63.60 | FQHC | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 69.10 | CMHC | | | | | | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERA | | | | | | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | | | | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | |
| 85.01 | PANCREAS ACQUISITION | | | | | | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | | | | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | | | | | | 85.03 |
| 95 | SUBTOTALS | 25335 | 25335 | 5138063 | -1484751 | 6870478 | 18582 | 200441 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & C | 336 | 336 | | | 3259 | 336 | | 96 |
| 96.01 | VENDING MACHINE | 100 | | | | 15481 | 100 | | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | | | | | 102 |
| 103 | COST TO BE ALLOC PER B PT I | 53342 | 195913 | 72699 | | 1484751 | 398136 | 141543 | 103 |
| 104 | UNIT COST MULT-WS B PT I | | 7.631686 | | | | 20.934693 | | 104 |
| 104 | UNIT COST MULT-WS B PT I | 2.069846 | | .014149 | | .215518 | | .706158 | 104 |
| 105 | COST TO BE ALLOC PER B PT II | | | | | | | | 105 |
| 106 | UNIT COST MULT-WS B PT II | | | | | | | | 106 |
| 106 | UNIT COST MULT-WS B PT II | | | | | | | | 106 |
| 107 | COST TO BE ALLOC PER B PT III | | | | | 40727 | 26723 | 13366 | 107 |
| 108 | UNIT COST MULT-WS B PT III | | | | | | 1.405142 | | 108 |
| 108 | UNIT COST MULT-WS B PT III | | | | | .005912 | | .066683 | 108 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| | COST CENTER DESCRIPTION | HOUSE-KEEPING SQUARE FEET 10 | DIETARY MEALS SERVED 11 | CAFETERIA FTE'S SERVED 12 | NURSING ADMINISTRATION DIRECT NRSING HRS 14 | CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15 | PHARMACY COSTED REQUIS. 16 | MEDICAL RECORDS & LIBRARY TIME SPENT 17 | SOCIAL SERVICE PATIENT DAYS 18 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 | OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 3 |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 4 |
| 5 | EMPLOYEE BENEFITS | | | | | | | | | 5 |
| 6 | ADMINISTRATIVE & GENERAL | | | | | | | | | 6 |
| 7 | MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 | OPERATION OF PLANT | | | | | | | | | 8 |
| 9 | LAUNDRY & LINEN SERVICE | | | | | | | | | 9 |
| 10 | HOUSEKEEPING | 17826 | | | | | | | | 10 |
| 11 | DIETARY | 1174 | 24759 | | | | | | | 11 |
| 12 | CAFETERIA | 480 | 10630 | 9730 | | | | | | 12 |
| 13 | MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 | NURSING ADMINISTRATION | 2387 | | 164 | 80613 | | | | | 14 |
| 15 | CENTRAL SERVICES & SUPPLY | | | 13 | 2255 | 689683 | | | | 15 |
| 16 | PHARMACY | 504 | | 296 | | 36976 | 383417 | | | 16 |
| 17 | MEDICAL RECORDS & LIBRARY | 1116 | | 792 | | 9109 | | 86530 | | 17 |
| 18 | SOCIAL SERVICE | 220 | | 80 | | 1279 | | | 2876 | 18 |
| 20 | NONPHYSICIAN ANESTHETISTS | | | | | | | | | 20 |
| 21 | NURSING SCHOOL | | | | | | | | | 21 |
| 22 | I&R SERVICES-SALARY & FRINGES | | | | | | | | | 22 |
| 23 | I&R SERVICES-OTHER PRGM COSTS | | | | | | | | | 23 |
| 24 | PARAMED ED PRGM-(SPECIFY) | | | | | | | | | 24 |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 | ADULTS & PEDIATRICS | 5483 | 14129 | 3339 | 78358 | 76713 | | 55740 | 2876 | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 1767 | | 1002 | | 20075 | | 7460 | | 41 |
| 44 | LABORATORY | 680 | | 901 | | 376395 | | 3200 | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN | | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 504 | | 448 | | 7704 | | | | 49 |
| 50 | PHYSICAL THERAPY | 980 | | 229 | | 8578 | | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 252 | | 45 | | | | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO P | 532 | | 41 | | 128116 | | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | | | | | | 369959 | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 | EMERGENCY | 1311 | | 760 | | 8280 | | 530 | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINC | | | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | | 1620 | | 16458 | 13458 | 19600 | | 63.50 |
| 63.60 | FQHC | | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 | CMHC | | | | | | | | | 69.10 |
| 69.20 | OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 | OUTPATIENT OCCUPATIONAL THERA | | | | | | | | | 69.30 |
| 69.40 | OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 | HOME HEALTH AGENCY | | | | | | | | | 71 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 | PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 | INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 | ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 | SUBTOTALS | 17390 | 24759 | 9730 | 80613 | 689683 | 383417 | 86530 | 2876 | 95 |
| | NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 | GIFT, FLOWER, COFFEE SHOP & C | 336 | | | | | | | | 96 |
| 96.01 | VENDING MACHINE | 100 | | | | | | | | 96.01 |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 | COST TO BE ALLOC PER B PT I | 175076 | 222426 | 185786 | 201456 | 11275 | 327305 | 395738 | 86956 | 103 |
| 104 | UNIT COST MULT-WS B PT I | 9.821384 | | 19.094142 | | .016348 | | 4.573420 | | 104 |
| 104 | UNIT COST MULT-WS B PT I | | 8.983642 | | 2.499051 | | .853653 | | 30.235049 | 104 |
| 105 | COST TO BE ALLOC PER B PT II | | | | | | | | | 105 |
| 106 | UNIT COST MULT-WS B PT II | | | | | | | | | 106 |
| 106 | UNIT COST MULT-WS B PT II | | | | | | | | | 106 |
| 107 | COST TO BE ALLOC PER B PT III | 1715 | 14521 | 11978 | 27552 | 813 | 7539 | 15172 | 2946 | 107 |
| 108 | UNIT COST MULT-WS B PT III | .096208 | | 1.231038 | | .001179 | | .175338 | | 108 |
| 108 | UNIT COST MULT-WS B PT III | | .586494 | | .341781 | | .019663 | | 1.024339 | 108 |

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

| | COST CENTER DESCRIPTION | TOTAL COST (FROM WKST B, PART I, COL 27) 1 | THERAPY LIMIT ADJUSTMENT 2 | TOTAL COSTS 3 | RCE DISALLOWANCE 4 | TOTAL COSTS 5 | |
|---|---|---|---|---|---|---|---|
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 25 | ADULTS & PEDIATRICS | 2639725 | | | | | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 1006257 | | | | | 41 |
| 44 | LABORATORY | 1218674 | | | | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMI | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 263038 | | | | | 49 |
| 50 | PHYSICAL THERAPY | 239422 | | | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 64899 | | | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO | 201559 | | | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 765509 | | | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 61 | EMERGENCY | 696209 | | | | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTI | 273155 | | 273155 | | 273155 | 62 |
| 63.50 | RURAL HEALTH CLINIC | 1242490 | | | | | 63.50 |
| 63.60 | FQHC | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 | SUBTOTAL | 8610937 | | 273155 | | 273155 | 101 |
| 102 | LESS OBSERVATION BEDS | 273155 | | 273155 | | 273155 | 102 |
| 103 | TOTAL | 8337782 | | | | | 103 |

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

| | COST CENTER DESCRIPTION | CHARGES | | | COST OR OTHER RATIO | TEFRA INPATIENT RATIO | PPS INPATIENT RATIO | |
|---|---|---|---|---|---|---|---|---|
| | | INPATIENT 6 | OUTPATIENT 7 | TOTAL 8 | 9 | 10 | 11 | |
| | INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 25 | ADULTS & PEDIATRICS | 1160007 | | 1160007 | | | | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 522819 | 2374138 | 2896957 | .347350 | | | 41 |
| 44 | LABORATORY | 703092 | 1676803 | 2379895 | .512070 | | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMI | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 454980 | 349184 | 804164 | .327095 | | | 49 |
| 50 | PHYSICAL THERAPY | 153753 | 753056 | 906809 | .264027 | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 230851 | 147530 | 378381 | .171518 | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO | 670437 | 148228 | 818665 | .246204 | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 1066690 | 552992 | 1619682 | .472629 | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 | EMERGENCY | 22365 | 429666 | 452031 | 1.540180 | | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTI | 15949 | 154755 | 170704 | 1.600168 | 1.600168 | 1.600168 | 62 |
| 63.50 | RURAL HEALTH CLINIC | | 721215 | 721215 | 1.722773 | | | 63.50 |
| 63.60 | FQHC | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 101 | SUBTOTAL | 5000943 | 7307567 | 12308510 | | | | 101 |
| 102 | LESS OBSERVATION BEDS | | | | | | | 102 |
| 103 | TOTAL | | | 12308510 | | | | 103 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

| | | | | |
|---|---|---|---|---|
| CHECK APPLICABLE BOXES | [ ] TITLE V - O/P | [XX] HOSPITAL (14-1328) | [ ] SNF | |
| | [XX] TITLE XVIII-PT B | [ ] SUB I | [ ] NF | |
| | [ ] TITLE XIX - O/P | [ ] SUB II | [ ] S/B-SNF | |
| | | [ ] SUB III | [ ] S/B-NF | |
| | | [ ] SUB IV | [ ] ICF/MR | |

| | COST CENTER DESCRIPTION | COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8 | PART I COL. 9 | PART II COL. 9 | PROGRAM CHARGES - OUTPATIENT AMBULATORY SURGICAL CENTER | OUTPATIENT RADIOLOGY | OTHER OUTPATIENT DIAGNOSTIC | |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 1.01 | 1.02 | 2 | 3 | 4 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | .347350 | .347350 | .347350 | | | | 41 |
| 44 | LABORATORY | .512070 | .512070 | .512070 | | | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | .327095 | .327095 | .327095 | | | | 49 |
| 50 | PHYSICAL THERAPY | .264027 | .264027 | .264027 | | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | .171518 | .171518 | .171518 | | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | .246204 | .246204 | .246204 | | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | .472629 | .472629 | .472629 | | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 61 | EMERGENCY | 1.540180 | 1.540180 | 1.540180 | | | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | 1.600168 | 1.600168 | 1.600168 | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | 1.722773 | 1.722773 | 1.722773 | | | | 63.50 |
| 63.60 | FQHC | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 65.01 | AMBULANCE SERVICES (2ND PERIOD) | | | | | | | 65.01 |
| 65.02 | AMBULANCE SERVICES (3RD PERIOD) | | | | | | | 65.02 |
| 65.03 | AMBULANCE SERVICES (4TH PERIOD) | | | | | | | 65.03 |
| 101 | SUBTOTAL | | | | | | | 101 |
| 102 | CRNA CHARGES | | | | | | | 102 |
| 103 | LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS | | | | | | | 103 |
| 104 | NET CHARGES | | | | | | | 104 |

PART VI - VACCINE COST APPORTIONMENT

| | | 1 | |
|---|---|---|---|
| 1 | DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES | .472629 | 1 |
| 2 | VACCINE CHARGES (OTHER THAN HEPATITIS B) | | 2 |
| 2.01 | VACCINE CHARGES - HEPATITIS B | | 2.01 |
| 3 | VACCINE COSTS (OTHER THAN HEPATITIS B) | | 3 |
| 3.01 | VACCINE COSTS - HEPATITIS B | | 3.01 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

| | | | | | |
|---|---|---|---|---|---|
| CHECK APPLICABLE BOXES | [ ] | TITLE V - O/P | [XX] | HOSPITAL (14-1328) | [ ] SNF |
| | [XX] | TITLE XVIII-PT B | [ ] | SUB I | [ ] NF |
| | [ ] | TITLE XIX - O/P | [ ] | SUB II | [ ] S/B-SNF |
| | | | [ ] | SUB III | [ ] S/B-NF |
| | | | [ ] | SUB IV | [ ] ICF/MR |

| | COST CENTER DESCRIPTION | PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5 | PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.01 | PROGRAM CHARGES ALL OTHER (SEE INSTRU.) 5.02 | PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.03 | PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.04 | PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6 | PROGRAM COST OUTPATIENT RADIOLOGY 7 | PROGRAM COST OTHER OUTPATIENT DIAGNOSTIC 8 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 658689 | | | | | | | | 41 |
| 44 | LABORATORY | 894045 | | | | | | | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN C | | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 65594 | | | | | | | | 49 |
| 50 | PHYSICAL THERAPY | 210396 | | | | | | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 68482 | | | | | | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PA | 92271 | | | | | | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 216260 | | | | | | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 61 | EMERGENCY | 113968 | | | | | | | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | 47670 | | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | | | | | | | | 63.50 |
| 63.60 | FQHC | | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 65.01 | AMBULANCE SERVICES (2ND PERIOD | | | | | | | | | 65.01 |
| 65.02 | AMBULANCE SERVICES (3RD PERIOD | | | | | | | | | 65.02 |
| 65.03 | AMBULANCE SERVICES (4TH PERIOD | | | | | | | | | 65.03 |
| 101 | SUBTOTAL | 2367375 | | | | | | | | 101 |
| 102 | CRNA CHARGES | | | | | | | | | 102 |
| 103 | PBP CLINIC LAB | | | | | | | | | 103 |
| 104 | NET CHARGES | 2367375 | | | | | | | | 104 |

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

| | | | | | |
|---|---|---|---|---|---|
| CHECK | [ ] | TITLE V - O/P | [XX] | HOSPITAL (14-1328) | [ ] SNF |
| APPLICABLE | [XX] | TITLE XVIII-PT B | [ ] | SUB I | [ ] NF |
| BOXES | [ ] | TITLE XIX - O/P | [ ] | SUB II | [ ] S/B-SNF |
| | | | [ ] | SUB III | [ ] S/B-NF |
| | | | [ ] | SUB IV | [ ] ICF/MR |

| | COST CENTER DESCRIPTION | PROGRAM COST ALL OTHER (COLS 1x5) 9 | PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01 | PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02) 9.02 | PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03 9.03 | PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.04 9.04 | HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10 | HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11 | |
|---|---|---|---|---|---|---|---|---|---|
| | ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | 228796 | | | | | | | 41 |
| 44 | LABORATORY | 457814 | | | | | | | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | 21455 | | | | | | | 49 |
| 50 | PHYSICAL THERAPY | 55550 | | | | | | | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | | | | | 52 |
| 53 | ELECTROCARDIOLOGY | 11746 | | | | | | | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | 22717 | | | | | | | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | 102211 | | | | | | | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 61 | EMERGENCY | 175531 | | | | | | | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | 76280 | | | | | | | 62 |
| 63.50 | RURAL HEALTH CLINIC | | | | | | | | 63.50 |
| 63.60 | FQHC | | | | | | | | 63.60 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | | | |
| 65.01 | AMBULANCE SERVICES (2ND PERIOD) | | | | | | | | 65.01 |
| 65.02 | AMBULANCE SERVICES (3RD PERIOD) | | | | | | | | 65.02 |
| 65.03 | AMBULANCE SERVICES (4TH PERIOD) | | | | | | | | 65.03 |
| 101 | SUBTOTAL | 1152100 | | | | | | | 101 |
| 102 | CRNA CHARGES | | | | | | | | 102 |
| 103 | LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS | | | | | | | | 103 |
| 104 | NET CHARGES | 1152100 | | | | | | | 104 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | INPATIENT DAYS | HOSPITAL (OTHER) (14-1328) 1 | SUB I 1 | SUB II 1 | SUB III 1 | SUB IV 1 | SNF 1 | |
|---|---|---|---|---|---|---|---|---|
| 1 | INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN) | 4399 | | | | | | 1 |
| 2 | INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) | 3315 | | | | | | 2 |
| 3 | PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | | | | | | | 3 |
| 4 | SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | 3315 | | | | | | 4 |
| 5 | TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 673 | | | | | | 5 |
| 6 | TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 225 | | | | | | 6 |
| 7 | TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 140 | | | | | | 7 |
| 8 | TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 46 | | | | | | 8 |
| 9 | INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) | 2215 | | | | | | 9 |
| 10 | SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 673 | | | | | | 10 |
| 11 | SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 225 | | | | | | 11 |
| 12 | SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 12 |
| 13 | SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 13 |
| 14 | MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS) | | | | | | | 14 |
| 15 | TOTAL NURSERY DAYS | | | | | | | 15 |
| 16 | TITLE V OR XIX NURSERY DAYS | | | | | | | 16 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | SNF | |
|---|---|---|---|---|---|---|---|---|
| | SWING-BED ADJUSTMENT | 1 | 1 | 1 | 1 | 1 | 1 | |
| 17 | MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 17 |
| 18 | MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 18 |
| 19 | MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 98.38 | | | | | | 19 |
| 20 | MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 98.38 | | | | | | 20 |
| 21 | TOTAL GENERAL INPATIENT ROUTINE SERVICE COST | 2639725 | | | | | | 21 |
| 22 | SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 22 |
| 23 | SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 23 |
| 24 | SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 13773 | | | | | | 24 |
| 25 | SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 4525 | | | | | | 25 |
| 26 | TOTAL SWING-BED COST | 577052 | | | | | | 26 |
| 27 | GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST | 2062673 | | | | | | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | | | | |
| 28 | GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES) | 1160007 | | | | | | 28 |
| 29 | PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | | | | | | | 29 |
| 30 | SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | 1160007 | | | | | | 30 |
| 31 | GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO | 1.778156 | | | | | | 31 |
| 32 | AVERAGE PRIVATE ROOM PER DIEM CHARGE | | | | | | | 32 |
| 33 | AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE | 349.93 | | | | | | 33 |
| 34 | AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL | | | | | | | 34 |
| 35 | AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL | | | | | | | 35 |
| 36 | PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT | | | | | | | 36 |
| 37 | GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL | 2062673 | | | | | | 37 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | 1 | 1 | 1 | 1 | 1 | |
| 38 | ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | 622.22 | | | | | 38 |
| 39 | PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 1378217 | | | | | 39 |
| 40 | MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM | | | | | | 40 |
| 41 | TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 1378217 | | | | | 41 |

| | | TOTAL I/P COST 1 | TOTAL I/P DAYS 2 | AVERAGE PER DIEM 3 | PROGRAM DAYS 4 | PROGRAM COST 5 | |
|---|---|---|---|---|---|---|---|
| 42 | NURSERY (TITLES V AND XIX ONLY) | | | | | | 42 |
| | INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS | | | | | | |
| 43 | INTENSIVE CARE UNIT | | | | | | 43 |
| 44 | CORONARY CARE UNIT | | | | | | 44 |
| 45 | BURN INTENSIVE CARE UNIT | | | | | | 45 |
| 46 | SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| 47 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47 |

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | | 1 | 1 | 1 | 1 | 1 | |
| 48 | PROGRAM INPATIENT ANCILLARY SERVICE COST | 882449 | | | | | 48 |
| 49 | TOTAL PROGRAM INPATIENT COSTS | 2260666 | | | | | 49 |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 50 | PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES | | | | | | 50 |
| 51 | PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES | | | | | | 51 |
| 52 | TOTAL PROGRAM EXCLUDABLE COST | | | | | | 52 |
| 53 | TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS | | | | | | 53 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | TARGET AMOUNT AND LIMITATION COMPUTATION | 1 | 1 | 1 | 1 | 1 | |
| 54 | PROGRAM DISCHARGES | | | | | | 54 |
| 55 | TARGET AMOUNT PER DISCHARGE | | | | | | 55 |
| 56 | TARGET AMOUNT | | | | | | 56 |
| 57 | DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT | | | | | | 57 |
| 58 | BONUS PAYMENT | | | | | | 58 |
| 58.01 | LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET | | | | | | 58.01 |
| 58.02 | LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET | | | | | | 58.02 |
| 58.03 | IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT | | | | | | 58.03 |
| 58.04 | RELIEF PAYMENT | | | | | | 58.04 |
| 59 | ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT | | | | | | 59 |
| 59.01 | ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) | | | | | | 59.01 |
| 59.02 | PROGRAM DISCHARGES PRIOR TO JULY 1 | | | | | | 59.02 |
| 59.03 | PROGRAM DISCHARGES AFTER JULY 1 | | | | | | 59.03 |
| 59.04 | PROGRAM DISCHARGES (SEE INSTRUCTIONS) | | | | | | 59.04 |
| 59.05 | REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1 | | | | | | 59.05 |
| 59.06 | REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 | | | | | | 59.06 |
| 59.07 | REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) | | | | | | 59.07 |
| 59.08 | REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.) | | | | | | 59.08 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 60 | MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 418754 | | | | | 60 |
| 61 | MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 140000 | | | | | 61 |
| 62 | TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS | 558754 | | | | | 62 |
| 63 | TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 63 |
| 64 | TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 64 |
| 65 | TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS | | | | | | 65 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

| | | SNF | |
|---|---|---|---|
| | | 1 | |
| 66 | SNF/NF/ICF/MR ROUTINE SERVICE COST | | 66 |
| 67 | ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | | 67 |
| 68 | PROGRAM ROUTINE SERVICE COST | | 68 |
| 69 | MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM | | 69 |
| 70 | TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS | | 70 |
| 71 | CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS | | 71 |
| 72 | PER DIEM CAPITAL RELATED COSTS | | 72 |
| 73 | PROGRAM CAPITAL RELATED COSTS | | 73 |
| 74 | INPATIENT ROUTINE SERVICE COST | | 74 |
| 75 | AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS | | 75 |
| 76 | TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT | | 76 |
| 77 | INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION | | 77 |
| 78 | INPATIENT ROUTINE SERVICE COST LIMITATION | | 78 |
| 79 | REASONABLE INPATIENT ROUTINE SERVICE COSTS | | 79 |
| 80 | PROGRAM INPATIENT ANCILLARY SERVICES | | 80 |
| 81 | UTILIZATION REVIEW--PHYSICIAN COMPENSATION | | 81 |
| 82 | TOTAL PROGRAM INPATIENT OPERATING COSTS | | 82 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | | 1 | 1 | 1 | 1 | 1 | |
| PART IV - COMPUTATION OF OBSERVATION BED COST | | | | | | | |
| 83 TOTAL OBSERVATION BEDS | | 439 | | | | | 83 |
| 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM | | 622.22 | | | | | 84 |
| 85 OBSERVATION BED COST | | 273155 | | | | | 85 |

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART I

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | INPATIENT DAYS | HOSPITAL (OTHER) (14-1328) 1 | SUB I 1 | SUB II 1 | SUB III 1 | SUB IV 1 | NF 1 | |
|---|---|---|---|---|---|---|---|---|
| 1 | INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN) | 4399 | | | | | | 1 |
| 2 | INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) | 3315 | | | | | | 2 |
| 3 | PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | | | | | | | 3 |
| 4 | SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | 3315 | | | | | | 4 |
| 5 | TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 673 | | | | | | 5 |
| 6 | TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 225 | | | | | | 6 |
| 7 | TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 140 | | | | | | 7 |
| 8 | TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 46 | | | | | | 8 |
| 9 | INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS) | 402 | | | | | | 9 |
| 10 | SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 10 |
| 11 | SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 11 |
| 12 | SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 12 |
| 13 | SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 13 |
| 14 | MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS) | | | | | | | 14 |
| 15 | TOTAL NURSERY DAYS | | | | | | | 15 |
| 16 | TITLE V OR XIX NURSERY DAYS | | | | | | | 16 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | NF | |
|---|---|---|---|---|---|---|---|---|
| | SWING-BED ADJUSTMENT | 1 | 1 | 1 | 1 | 1 | 1 | |
| 17 | MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 17 |
| 18 | MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 18 |
| 19 | MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 98.38 | | | | | | 19 |
| 20 | MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 98.38 | | | | | | 20 |
| 21 | TOTAL GENERAL INPATIENT ROUTINE SERVICE COST | 2639725 | | | | | | 21 |
| 22 | SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 22 |
| 23 | SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 23 |
| 24 | SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 13773 | | | | | | 24 |
| 25 | SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | 4525 | | | | | | 25 |
| 26 | TOTAL SWING-BED COST | 577052 | | | | | | 26 |
| 27 | GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST | 2062673 | | | | | | 27 |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | | | | |
| 28 | GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES) | 1160007 | | | | | | 28 |
| 29 | PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | | | | | | | 29 |
| 30 | SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | 1160007 | | | | | | 30 |
| 31 | GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO | 1.778156 | | | | | | 31 |
| 32 | AVERAGE PRIVATE ROOM PER DIEM CHARGE | | | | | | | 32 |
| 33 | AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE | 349.93 | | | | | | 33 |
| 34 | AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL | | | | | | | 34 |
| 35 | AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL | | | | | | | 35 |
| 36 | PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT | | | | | | | 36 |
| 37 | GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL | 2062673 | | | | | | 37 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS | 1 | 1 | 1 | 1 | 1 | |
| 38 | ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | 622.22 | | | | | 38 |
| 39 | PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 250132 | | | | | 39 |
| 40 | MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM | | | | | | 40 |
| 41 | TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 250132 | | | | | 41 |

| | | TOTAL I/P COST 1 | TOTAL I/P DAYS 2 | AVERAGE PER DIEM 3 | PROGRAM DAYS 4 | PROGRAM COST 5 | |
|---|---|---|---|---|---|---|---|
| 42 | NURSERY (TITLES V AND XIX ONLY) | | | | | | 42 |
| | INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS | | | | | | |
| 43 | INTENSIVE CARE UNIT | | | | | | 43 |
| 44 | CORONARY CARE UNIT | | | | | | 44 |
| 45 | BURN INTENSIVE CARE UNIT | | | | | | 45 |
| 46 | SURGICAL INTENSIVE CARE UNIT | | | | | | 46 |
| 47 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47 |

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | | 1 | 1 | 1 | 1 | 1 | |
| 48 | PROGRAM INPATIENT ANCILLARY SERVICE COST | 221401 | | | | | 48 |
| 49 | TOTAL PROGRAM INPATIENT COSTS | 471533 | | | | | 49 |
| | PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 50 | PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES | 12482 | | | | | 50 |
| 51 | PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES | 4094 | | | | | 51 |
| 52 | TOTAL PROGRAM EXCLUDABLE COST | 16576 | | | | | 52 |
| 53 | TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS | | | | | | 53 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

| | TARGET AMOUNT AND LIMITATION COMPUTATION | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | | 1 | 1 | 1 | 1 | 1 | |
| 54 | PROGRAM DISCHARGES | | | | | | 54 |
| 55 | TARGET AMOUNT PER DISCHARGE | | | | | | 55 |
| 56 | TARGET AMOUNT | | | | | | 56 |
| 57 | DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT | | | | | | 57 |
| 58 | BONUS PAYMENT | | | | | | 58 |
| 58.01 | LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET | | | | | | 58.01 |
| 58.02 | LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET | | | | | | 58.02 |
| 58.03 | IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT | | | | | | 58.03 |
| 58.04 | RELIEF PAYMENT | | | | | | 58.04 |
| 59 | ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT | | | | | | 59 |
| 59.01 | ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) | | | | | | 59.01 |
| 59.02 | PROGRAM DISCHARGES PRIOR TO JULY 1 | | | | | | 59.02 |
| 59.03 | PROGRAM DISCHARGES AFTER JULY 1 | | | | | | 59.03 |
| 59.04 | PROGRAM DISCHARGES (SEE INSTRUCTIONS) | | | | | | 59.04 |
| 59.05 | REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1 | | | | | | 59.05 |
| 59.06 | REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 | | | | | | 59.06 |
| 59.07 | REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) | | | | | | 59.07 |
| 59.08 | REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.) | | | | | | 59.08 |

PROGRAM INPATIENT ROUTINE SWING BED COST

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 60 | MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 60 |
| 61 | MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 61 |
| 62 | TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS | | | | | | 62 |
| 63 | TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 63 |
| 64 | TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 64 |
| 65 | TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS | | | | | | 65 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

| | | NF | |
|---|---|---|---|
| | | 1 | |
| 66 | SNF/NF/ICF/MR ROUTINE SERVICE COST | | 66 |
| 67 | ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM | | 67 |
| 68 | PROGRAM ROUTINE SERVICE COST | | 68 |
| 69 | MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM | | 69 |
| 70 | TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS | | 70 |
| 71 | CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS | | 71 |
| 72 | PER DIEM CAPITAL RELATED COSTS | | 72 |
| 73 | PROGRAM CAPITAL RELATED COSTS | | 73 |
| 74 | INPATIENT ROUTINE SERVICE COST | | 74 |
| 75 | AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS | | 75 |
| 76 | TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT | | 76 |
| 77 | INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION | | 77 |
| 78 | INPATIENT ROUTINE SERVICE COST LIMITATION | | 78 |
| 79 | REASONABLE INPATIENT ROUTINE SERVICE COSTS | | 79 |
| 80 | PROGRAM INPATIENT ANCILLARY SERVICES | | 80 |
| 81 | UTILIZATION REVIEW--PHYSICIAN COMPENSATION | | 81 |
| 82 | TOTAL PROGRAM INPATIENT OPERATING COSTS | | 82 |

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

| | | HOSPITAL (OTHER) (14-1328) | SUB I | SUB II | SUB III | SUB IV | |
|---|---|---|---|---|---|---|---|
| | | 1 | 1 | 1 | 1 | 1 | |
| PART IV - COMPUTATION OF OBSERVATION BED COST | | | | | | | |
| 83 | TOTAL OBSERVATION BEDS | 439 | | | | | 83 |
| 84 | ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM | 622.22 | | | | | 84 |
| 85 | OBSERVATION BED COST | 273155 | | | | | 85 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V
[XX] TITLE XVIII-PT A
[ ] TITLE XIX

[XX] HOSPITAL (14-1328)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] ICF/MR

[ ] PPS
[ ] TEFRA
[XX] OTHER

| | COST CENTER DESCRIPTION | RATIO OF COST TO CHARGES 1 | INPATIENT PROGRAM CHARGES 2 | INPATIENT PROGRAM COSTS 3 | |
|---|---|---|---|---|---|
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 25 | ADULTS & PEDIATRICS | | 876033 | | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | .347350 | 302215 | 104974 | 41 |
| 44 | LABORATORY | .512070 | 489875 | 250850 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | .327095 | 270599 | 88512 | 49 |
| 50 | PHYSICAL THERAPY | .264027 | 27895 | 7365 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | 52 |
| 53 | ELECTROCARDIOLOGY | .171518 | 177235 | 30399 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | .246204 | 384415 | 94645 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | .472629 | 633743 | 299525 | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 | EMERGENCY | 1.540180 | 4012 | 6179 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | 1.600168 | | | 62 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 | RURAL HEALTH CLINIC | 1.722773 | | | 63.50 |
| 63.60 | FQHC | | | | 63.60 |
| 101 | TOTAL | | 2289989 | 882449 | 101 |
| 102 | LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 | NET CHARGES | | 2289989 | | 103 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|---|---|---|---|
| [ ] TITLE V | [ ] HOSPITAL | [ ] SNF | [ ] PPS |
| [XX] TITLE XVIII-PT A | [ ] SUB I | [ ] NF | [ ] TEFRA |
| [ ] TITLE XIX | [ ] SUB II | [XX] S/B-SNF (14-Z328) | [XX] OTHER |
| | [ ] SUB III | [ ] S/B-NF | |
| | [ ] SUB IV | [ ] ICF/MR | |

| | COST CENTER DESCRIPTION | RATIO OF COST TO CHARGES 1 | INPATIENT PROGRAM CHARGES 2 | INPATIENT PROGRAM COSTS 3 | |
|---|---|---|---|---|---|
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 25 | ADULTS & PEDIATRICS | | | | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | .347350 | 28802 | 10004 | 41 |
| 44 | LABORATORY | .512070 | 73270 | 37519 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | .327095 | 76204 | 24926 | 49 |
| 50 | PHYSICAL THERAPY | .264027 | 110319 | 29127 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | 52 |
| 53 | ELECTROCARDIOLOGY | .171518 | 9930 | 1703 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | .246204 | 121695 | 29962 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | .472629 | 182674 | 86337 | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 | EMERGENCY | 1.540180 | 748 | 1152 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | 1.600168 | | | 62 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 | RURAL HEALTH CLINIC | 1.722773 | | | 63.50 |
| 63.60 | FQHC | | | | 63.60 |
| 101 | TOTAL | | 603642 | 220730 | 101 |
| 102 | LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 | NET CHARGES | | 603642 | | 103 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|---|---|---|---|
| [ ] TITLE V | [XX] HOSPITAL (14-1328) | [ ] SNF | [ ] PPS |
| [ ] TITLE XVIII-PT A | [ ] SUB I | [ ] NF | [ ] TEFRA |
| [XX] TITLE XIX | [ ] SUB II | [ ] S/B-SNF | [XX] OTHER |
| | [ ] SUB III | [ ] S/B-NF | |
| | [ ] SUB IV | [ ] ICF/MR | |

| | COST CENTER DESCRIPTION | RATIO OF COST TO CHARGES 1 | INPATIENT PROGRAM CHARGES 2 | INPATIENT PROGRAM COSTS 3 | |
|---|---|---|---|---|---|
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 25 | ADULTS & PEDIATRICS | | 161668 | | 25 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 41 | RADIOLOGY-DIAGNOSTIC | .347350 | 75731 | 26305 | 41 |
| 44 | LABORATORY | .512070 | 127081 | 65074 | 44 |
| 46.30 | BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 | RESPIRATORY THERAPY | .327095 | 53846 | 17613 | 49 |
| 50 | PHYSICAL THERAPY | .264027 | 2333 | 616 | 50 |
| 51 | OCCUPATIONAL THERAPY | | | | 51 |
| 52 | SPEECH PATHOLOGY | | | | 52 |
| 53 | ELECTROCARDIOLOGY | .171518 | 22686 | 3891 | 53 |
| 55 | MEDICAL SUPPLIES CHARGED TO PAT | .246204 | 57037 | 14043 | 55 |
| 56 | DRUGS CHARGED TO PATIENTS | .472629 | 160691 | 75947 | 56 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 61 | EMERGENCY | 1.540180 | 9743 | 15006 | 61 |
| 62 | OBSERVATION BEDS (NON-DISTINCT | 1.600168 | 1816 | 2906 | 62 |
| | OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 | RURAL HEALTH CLINIC | 1.722773 | | | 63.50 |
| 63.60 | FQHC | | | | 63.60 |
| 101 | TOTAL | | 510964 | 221401 | 101 |
| 102 | LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 | NET CHARGES | | 510964 | | 103 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | HOSPITAL (14-1328) 1 | HOSPITAL (14-1328) 1.01 | HOSPITAL (14-1328) 1.02 | |
|---|---|---|---|---|---|
| 1 | MEDICAL AND OTHER SERVICES | 1152100 | | | 1 |
| 1.01 | MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000 | | | | 1.01 |
| 1.02 | PPS PAYMENTS RECEIVED INCLUDING OUTLIERS | | | | 1.02 |
| 1.03 | 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO | | | | 1.03 |
| 1.04 | LINE 1.01 TIMES LINE 1.03 | | | | 1.04 |
| 1.05 | LINE 1.02 DIVIDED BY LINE 1.04 | | | | 1.05 |
| 1.06 | TRANSITIONAL CORRIDOR PAYMENT | | | | 1.06 |
| 1.07 | AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101 | | | | 1.07 |
| 2 | INTERNS AND RESIDENTS | | | | 2 |
| 3 | ORGAN ACQUISITIONS | | | | 3 |
| 4 | COST OF TEACHING PHYSICIANS | | | | 4 |
| 5 | TOTAL COST | 1152100 | | | 5 |
| | COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES | | | | |
| 6 | ANCILLARY SERVICE CHARGES | | | | 6 |
| 7 | INTERNS AND RESIDENTS SERVICE CHARGES | | | | 7 |
| 8 | ORGAN ACQUISITION CHARGES | | | | 8 |
| 9 | CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS | | | | 9 |
| 10 | TOTAL REASONABLE CHARGES | | | | 10 |
| | CUSTOMARY CHARGES | | | | |
| 11 | AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | | | 11 |
| 12 | AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) | | | | 12 |
| 13 | RATIO OF LINE 11 TO LINE 12 | | | | 13 |
| 14 | TOTAL CUSTOMARY CHARGES | | | | 14 |
| 15 | EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST | | | | 15 |
| 16 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | | 16 |
| 17 | LESSER OF COST OR CHARGES | 1163621 | | | 17 |
| 17.01 | TOTAL PPS PAYMENTS | | | | 17.01 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | | HOSPITAL (14-1328) 1 | HOSPITAL (14-1328) 1.01 | HOSPITAL (14-1328) 1.02 | |
|---|---|---|---|---|---|
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | |
| 18 | DEDUCTIBLES | 18918 | | | 18 |
| 18.01 | COINSURANCE | 322989 | | | 18.01 |
| 19 | SUBTOTAL | 821714 | | | 19 |
| 20 | SUM OF AMOUNTS FROM WKST E, PARTS C,D & E | | | | 20 |
| 21 | DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS | | | | 21 |
| 22 | ESRD DIRECT MEDICAL EDUCATION COSTS | | | | 22 |
| 23 | SUBTOTAL | 821714 | | | 23 |
| 24 | PRIMARY PAYER PAYMENTS | 107 | | | 24 |
| 25 | SUBTOTAL | 821607 | | | 25 |
| | REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | | |
| 26 | COMPOSITE RATE ESRD | | | | 26 |
| 27 | BAD DEBTS | 101388 | | | 27 |
| 27.01 | REDUCED REIMBURSABLE BAD DEBTS | 101388 | | | 27.01 |
| 27.02 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) | 98522 | | | 27.02 |
| 28 | SUBTOTAL | 922995 | | | 28 |
| 29 | RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION | | | | 29 |
| 30 | OTHER ADJUSTMENTS | | | | 30 |
| 30.99 | OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT) | | | | 30.99 |
| 31 | AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS | | | | 31 |
| 32 | SUBTOTAL | 922995 | | | 32 |
| 33 | SEQUESTRATION ADJUSTMENT | | | | 33 |
| 34 | INTERIM PAYMENTS | 914046 | | | 34 |
| 34.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | 34.01 |
| 35 | BALANCE DUE PROVIDER/PROGRAM | 8949 | | | 35 |
| 36 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | | | | 36 |

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

HOSPITAL (14-1328)

| | DESCRIPTION | | | INPATIENT PART A MM/DD/YYYY 1 | INPATIENT PART A AMOUNT 2 | PART B MM/DD/YYYY 3 | PART B AMOUNT 4 | |
|---|---|---|---|---|---|---|---|---|
| 1 | TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | | | 2088840 | | 914046 | 1 |
| 2 | INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO. | | | | NONE | | NONE | 2 |
| 3 | LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | | .01 | | | | | 3.01 |
| | | PROGRAM | .02 | | | | | 3.02 |
| | | TO | .03 | | NONE | | NONE | 3.03 |
| | | PROVIDER | .04 | | | | | 3.04 |
| | | | .05 | | | | | 3.05 |
| | | | .50 | | | | | 3.50 |
| | | PROVIDER | .51 | | | | | 3.51 |
| | | TO | .52 | | NONE | | NONE | 3.52 |
| | | PROGRAM | .53 | | | | | 3.53 |
| | | | .54 | | | | | 3.54 |
| | SUBTOTAL | | .99 | | | | | 3.99 |
| 4 | TOTAL INTERIM PAYMENTS | | | | 2088840 | | 914046 | 4 |
| | TO BE COMPLETED BY INTERMEDIARY | | | | | | | |
| 5 | LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM | .01 | | | | | 5.01 |
| | | TO | .02 | | NONE | | NONE | 5.02 |
| | | PROVIDER | .03 | | | | | 5.03 |
| | | PROVIDER | .50 | | | | | 5.50 |
| | | TO | .51 | | NONE | | NONE | 5.51 |
| | | PROGRAM | .52 | | | | | 5.52 |
| | SUBTOTAL | | .99 | | | | | 5.99 |
| 6 | DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO PROVIDER | .01 | | | | 8949 | 6.01 |
| | | PROVIDER TO PROGRAM | .02 | | -43277 | | | 6.02 |
| 7 | TOTAL MEDICARE PROGRAM LIABILITY | | | | 2045563 | | 922995 | 7 |

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

SWING BED SKILLED NURSING FACILITY (14-Z328)

| | DESCRIPTION | | | INPATIENT PART A MM/DD/YYYY 1 | INPATIENT PART A AMOUNT 2 | PART B MM/DD/YYYY 3 | PART B AMOUNT 4 | |
|---|---|---|---|---|---|---|---|---|
| 1 | TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | | | 776206 | | | 1 |
| 2 | INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO. | | | | NONE | | NONE | 2 |
| 3 | LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | | .01 | | | | | 3.01 |
| | | PROGRAM | .02 | | | | | 3.02 |
| | | TO | .03 | | NONE | | NONE | 3.03 |
| | | PROVIDER | .04 | | | | | 3.04 |
| | | | .05 | | | | | 3.05 |
| | | | .50 | | | | | 3.50 |
| | | PROVIDER | .51 | | | | | 3.51 |
| | | TO | .52 | | NONE | | NONE | 3.52 |
| | | PROGRAM | .53 | | | | | 3.53 |
| | | | .54 | | | | | 3.54 |
| | SUBTOTAL | | .99 | | | | | 3.99 |
| 4 | TOTAL INTERIM PAYMENTS | | | | 776206 | | | 4 |
| | TO BE COMPLETED BY INTERMEDIARY | | | | | | | |
| 5 | LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM | .01 | | | | | 5.01 |
| | | TO | .02 | | NONE | | NONE | 5.02 |
| | | PROVIDER | .03 | | | | | 5.03 |
| | | PROVIDER | .50 | | | | | 5.50 |
| | | TO | .51 | | NONE | | NONE | 5.51 |
| | | PROGRAM | .52 | | | | | 5.52 |
| | SUBTOTAL | | .99 | | | | | 5.99 |
| 6 | DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO PROVIDER | .01 | | | | | 6.01 |
| | | PROVIDER TO PROGRAM | .02 | | -2680 | | | 6.02 |
| 7 | TOTAL MEDICARE PROGRAM LIABILITY | | | | 773526 | | | 7 |

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

SUPPLEMENTAL
WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

| | | TITLE V S/B NF | --- TITLE XVIII --- S/B SNF PART A (14-Z328) | S/B SNF PART B | --- TITLE XIX --- S/B SNF (14-Z328) | S/B NF | |
|---|---|---|---|---|---|---|---|
| | | 1 | 1 | 2 | 1 | 1 | |
| 1 | INPATIENT ROUTINE SERVICES - SWING BED - SNF | | 564342 | | | | 1 |
| 2 | INPATIENT ROUTINE SERVICES - SWING BED - NF | | | | | | 2 |
| 3 | ANCILLARY SERVICES | | 222937 | | | | 3 |
| 4 | PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM | | | | | | 4 |
| 5 | PROGRAM DAYS | | 898 | | | | 5 |
| 6 | INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM | | | | | | 6 |
| 7 | UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY | | | | | | 7 |
| 8 | SUBTOTAL | | 787279 | | | | 8 |
| 9 | PRIMARY PAYER PAYMENTS | | | | | | 9 |
| 10 | SUBTOTAL | | 787279 | | | | 10 |
| 11 | DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES) | | | | | | 11 |
| 12 | SUBTOTAL | | 787279 | | | | 12 |
| 13 | COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES) | | 32892 | | | | 13 |
| 14 | 80% OF PART B COSTS | | | | | | 14 |
| 15 | SUBTOTAL | | 754387 | | | | 15 |
| 16 | OTHER ADJUSTMENTS | | | | | | 16 |
| 17 | REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES) | | 19139 | | | | 17 |
| 17.01 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES | | 19139 | | | | 17.01 |
| 18 | TOTAL | | 773526 | | | | 18 |
| 19 | SEQUESTRATION ADJUSTMENT | | | | | | 19 |
| 20 | INTERIM PAYMENTS | | 776206 | | | | 20 |
| 20.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | | 20.01 |
| 21 | BALANCE DUE PROVIDER/PROGRAM | | -2680 | | | | 21 |
| 22 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | | | | | | 22 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

| | | HOSPITAL (14-1328) | SUB I | SUB II | SUB III | SUB IV | SNF I | |
|---|---|---|---|---|---|---|---|---|
| 1 | INPATIENT SERVICES | 2260666 | | | | | | 1 |
| 1.01 | NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS) | | | | | | | 1.01 |
| 2 | ORGAN ACQUISITION | | | | | | | 2 |
| 3 | COST OF TEACHING PHYSICIANS | | | | | | | 3 |
| 4 | SUBTOTAL | 2260666 | | | | | | 4 |
| 5 | PRIMARY PAYER PAYMENTS | | | | | | | 5 |
| 6 | TOTAL COST | 2283273 | | | | | | 6 |
| | COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES | | | | | | | |
| 7 | ROUTINE SERVICE CHARGES | | | | | | | 7 |
| 8 | ANCILLARY SERVICE CHARGES | | | | | | | 8 |
| 9 | ORGAN ACQUISITION CHARGES, NET OF REVENUE | | | | | | | 9 |
| 10 | TEACHING PHYSICIANS | | | | | | | 10 |
| 11 | TOTAL REASONABLE CHARGES | | | | | | | 11 |
| 12 | AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS | | | | | | | 12 |
| 13 | AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E) | | | | | | | 13 |
| 14 | RATIO OF LINE 12 TO LINE 13 | | | | | | | 14 |
| 15 | TOTAL CUSTOMARY CHARGES | | | | | | | 15 |
| 16 | EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST | | | | | | | 16 |
| 17 | EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES | | | | | | | 17 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

| | | HOSPITAL (14-1328) | SUB I | SUB II | SUB III | SUB IV | SNF I | |
|---|---|---|---|---|---|---|---|---|
| | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | | | | | |
| 18 | DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS | | | | | | | 18 |
| 19 | COST OF COVERED SERVICES | 2283273 | | | | | | 19 |
| 20 | DEDUCTIBLES | 292919 | | | | | | 20 |
| 21 | EXCESS REASONABLE COST | | | | | | | 21 |
| 22 | SUBTOTAL | 1990354 | | | | | | 22 |
| 23 | COINSURANCE | 10736 | | | | | | 23 |
| 24 | SUBTOTAL | 1979618 | | | | | | 24 |
| 25 | REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | 64318 | | | | | | 25 |
| 25.01 | REDUCED REIMBURSABLE BAD DEBTS | 64318 | | | | | | 25.01 |
| 25.02 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) | 64318 | | | | | | 25.02 |
| 26 | SUBTOTAL | 2043936 | | | | | | 26 |
| 27 | RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION | | | | | | | 27 |
| 28 | PAYMENTS MADE UNDER MSP | 1627 | | | | | | 28 |
| 29 | AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS | | | | | | | 29 |
| 30 | SUBTOTAL | 2045563 | | | | | | 30 |
| 31 | SEQUESTRATION ADJUSTMENT | | | | | | | 31 |
| 32 | INTERIM PAYMENTS | 2088840 | | | | | | 32 |
| 32.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | | | 32.01 |
| 33 | BALANCE DUE PROVIDER/PROGRAM | -43277 | | | | | | 33 |
| 34 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2 | | | | | | | 34 |

BALANCE SHEET

WORKSHEET G

| | ASSETS | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| | CURRENT ASSETS | | | | | |
| 1 | CASH ON HAND AND IN BANKS | 96714 | | | | 1 |
| 2 | TEMPORARY INVESTMENTS | | | | | 2 |
| 3 | NOTES RECEIVABLE | | | | | 3 |
| 4 | ACCOUNTS RECEIVABLE | 2303327 | | | | 4 |
| 5 | OTHER RECEIVABLES | 598745 | | | | 5 |
| 6 | ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE | -743489 | | | | 6 |
| 7 | INVENTORY | 141346 | | | | 7 |
| 8 | PREPAID EXPENSES | 13388 | | | | 8 |
| 9 | OTHER CURRENT ASSETS | | | | | 9 |
| 10 | DUE FROM OTHER FUNDS | | | | | 10 |
| 11 | TOTAL CURRENT ASSETS | 2410031 | | | | 11 |
| | FIXED ASSETS | | | | | |
| 12 | LAND | 17000 | | | | 12 |
| 12.01 | ACCUMULATED DEPRECIATION | | | | | 12.01 |
| 13 | LAND IMPROVEMENTS | 100979 | | | | 13 |
| 13.01 | ACCUMULATED DEPRECIATION | -100979 | | | | 13.01 |
| 14 | BUILDINGS | 1391917 | | | | 14 |
| 14.01 | ACCUMULATED DEPRECIATION | -1079462 | | | | 14.01 |
| 15 | LEASEHOLD IMPROVEMENTS | | | | | 15 |
| 15.01 | ACCUMULATED AMORTIZATION | | | | | 15.01 |
| 16 | FIXED EQUIPMENT | | | | | 16 |
| 16.01 | ACCUMULATED DEPRECIATION | | | | | 16.01 |
| 17 | AUTOMOBILES AND TRUCKS | | | | | 17 |
| 17.01 | ACCUMULATED DEPRECIATION | | | | | 17.01 |
| 18 | MAJOR MOVABLE EQUIPMENT | 2277737 | | | | 18 |
| 18.01 | ACCUMULATED DEPRECIATION | -1780997 | | | | 18.01 |
| 19 | MINOR EQUIPMENT DEPRECIABLE | | | | | 19 |
| 19.01 | ACCUMULATED DEPRECIATION | | | | | 19.01 |
| 20 | MINOR EQUIPMENT-NONDEPRECIABLE | | | | | 20 |
| 21 | TOTAL FIXED ASSETS | 826195 | | | | 21 |
| | OTHER ASSETS | | | | | |
| 22 | INVESTMENTS | | | | | 22 |
| 23 | DEPOSITS ON LEASES | | | | | 23 |
| 24 | DUE FROM OWNERS/OFFICERS | | | | | 24 |
| 25 | OTHER ASSETS | | | | | 25 |
| 26 | TOTAL OTHER ASSETS | | | | | 26 |
| 27 | TOTAL ASSETS | 3236226 | | | | 27 |

| | LIABILITIES AND FUND BALANCES | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND | |
|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | |
| | CURRENT LIABILITIES | | | | | |
| 28 | ACCOUNTS PAYABLE | 494168 | | | | 28 |
| 29 | SALARIES, WAGES & FEES PAYABLE | 532510 | | | | 29 |
| 30 | PAYROLL TAXES PAYABLE | | | | | 30 |
| 31 | NOTES & LOANS PAYABLE (SHORT TERM) | 457885 | | | | 31 |
| 32 | DEFERRED INCOME | | | | | 32 |
| 33 | ACCELERATED PAYMENTS | | | | | 33 |
| 34 | DUE TO OTHER FUNDS | | | | | 34 |
| 35 | OTHER CURRENT LIABILITIES | 107652 | | | | 35 |
| 36 | TOTAL CURRENT LIABILITIES | 1592215 | | | | 36 |
| | LONG-TERM LIABILITIES | | | | | |
| 37 | MORTGAGE PAYABLE | | | | | 37 |
| 38 | NOTES PAYABLE | 836505 | | | | 38 |
| 39 | UNSECURED LOANS | | | | | 39 |
| 40 | LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66 | | | | | 40 |
| 41 | OTHER LONG TERM LIABILITIES | | | | | 41 |
| 42 | TOTAL LONG TERM LIABILITIES | 836505 | | | | 42 |
| 43 | TOTAL LIABILITIES | 2428720 | | | | 43 |
| | CAPITAL ACCOUNTS | | | | | |
| 44 | GENERAL FUND BALANCE | 807506 | | | | 44 |
| 45 | SPECIFIC PURPOSE FUND BALANCE | | | | | 45 |
| 46 | DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED | | | | | 46 |
| 47 | DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED | | | | | 47 |
| 48 | GOVERNING BODY CREATED - ENDOWMENT FUND BAL | | | | | 48 |
| 49 | PLANT FUND BALANCE - INVESTED IN PLANT | | | | | 49 |
| 50 | PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION | | | | | 50 |
| 51 | TOTAL FUND BALANCES | 807506 | | | | 51 |
| 52 | TOTAL LIABILITIES AND FUND BALANCES | 3236226 | | | | 52 |

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

| | | GENERAL FUND 1 | | SPECIFIC PURPOSE FUND 2 | ENDOWMENT FUND 3 | PLANT FUND 4 | |
|---|---|---|---|---|---|---|---|
| 1 | FUND BALANCES AT BEGINNING OF PERIOD | | 342444 | | | | 1 |
| 2 | NET INCOME (LOSS) | | 89373 | | | | 2 |
| 3 | TOTAL | | 431817 | | | | 3 |
| 4 | ADDITIONS (CREDIT ADJUSTMENTS) | | | | | | 4 |
| 5 | PRIOR YEAR ADJUSTMENTS | 375689 | | | | | 5 |
| 6 | | | | | | | 6 |
| 7 | | | | | | | 7 |
| 8 | | | | | | | 8 |
| 9 | | | | | | | 9 |
| 10 | TOTAL ADDITIONS | | 375689 | | | | 10 |
| 11 | SUBTOTAL | | 807506 | | | | 11 |
| 12 | DEDUCTIONS (DEBIT ADJUSTMENTS) | | | | | | 12 |
| 13 | | | | | | | 13 |
| 14 | | | | | | | 14 |
| 15 | | | | | | | 15 |
| 16 | | | | | | | 16 |
| 17 | | | | | | | 17 |
| 18 | TOTAL DEDUCTIONS | | | | | | 18 |
| 19 | FUND BALANCE AT END OF PERIOD PER BALANCE SHEET | | 807506 | | | | 19 |

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

| | REVENUE CENTER | INPATIENT 1 | OUTPATIENT 2 | TOTAL 3 | |
|---|---|---|---|---|---|
| | GENERAL INPATIENT ROUTINE CARE SERVICES | | | | |
| 1 | HOSPITAL | 1427844 | | 1427844 | 1 |
| 2 | SUBPROVIDER I | | | | 2 |
| 4 | SWING BED - SNF | 356459 | | 356459 | 4 |
| 5 | SWING BED - NF | | | | 5 |
| 6 | SKILLED NURSING FACILITY | | | | 6 |
| 7 | NURSING FACILITY | | | | 7 |
| 8 | OTHER LONG TERM CARE | | | | 8 |
| 9 | TOTAL GENERAL INPATIENT CARE SERVICES | 1784303 | | 1784303 | 9 |
| | INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES | | | | |
| 10 | INTENSIVE CARE UNIT | | | | 10 |
| 11 | CORONARY CARE UNIT | | | | 11 |
| 12 | BURN INTENSIVE CARE UNIT | | | | 12 |
| 13 | SURGICAL INTENSIVE CARE UNIT | | | | 13 |
| 14 | OTHER SPECIAL CARE (SPECIFY) | | | | 14 |
| 15 | TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE | | | | 15 |
| 16 | TOTAL INPATIENT ROUTINE CARE SERVICES | 1784303 | | 1784303 | 16 |
| 17 | ANCILLARY SERVICES | 3992218 | 6182527 | 10174745 | 17 |
| 18 | OUTPATIENT SERVICES | 52752 | 1178578 | 1231330 | 18 |
| 18.50 | RURAL HEALTH CLINIC | | 721215 | 721215 | 18.50 |
| 18.60 | FQHC | | | | 18.60 |
| 19 | HOME HEALTH AGENCY | | | | 19 |
| 20 | AMBULANCE | | | | 20 |
| 21 | CORF | | | | 21 |
| 22 | ASC | | | | 22 |
| 23 | HOSPICE | | | | 23 |
| 24 | | | | | 24 |
| 25 | TOTAL PATIENT REVENUES | 5829273 | 8082320 | 13911593 | 25 |

PART II - OPERATING EXPENSES

| | | 1 | 2 | |
|---|---|---|---|---|
| 26 | OPERATING EXPENSES | | 9890394 | 26 |
| 27 | ADD (SPECIFY) | | | 27 |
| 28 | | | | 28 |
| 29 | | | | 29 |
| 30 | | | | 30 |
| 31 | | | | 31 |
| 32 | | | | 32 |
| 33 | TOTAL ADDITIONS | | | 33 |
| 34 | DEDUCT (SPECIFY) | | | 34 |
| 35 | | | | 35 |
| 36 | | | | 36 |
| 37 | | | | 37 |
| 38 | | | | 38 |
| 39 | TOTAL DEDUCTIONS | | | 39 |
| 40 | TOTAL OPERATING EXPENSES | | 9890394 | 40 |

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

| | DESCRIPTION | | |
|---|---|---|---|
| 1 | TOTAL PATIENT REVENUES | 13911593 | 1 |
| 2 | LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS | 4085825 | 2 |
| 3 | NET PATIENT REVENUES | 9825768 | 3 |
| 4 | LESS - TOTAL OPERATING EXPENSES | 9890394 | 4 |
| 5 | NET INCOME FROM SERVICE TO PATIENTS | -64626 | 5 |
| 6 | CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. | 5 | 6 |
| 7 | INCOME FROM INVESTMENTS | 537 | 7 |
| 8 | REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE | | 8 |
| 9 | REVENUE FROM TELEVISION AND RADIO SERVICE | | 9 |
| 10 | PURCHASE DISCOUNTS | | 10 |
| 11 | REBATES AND REFUNDS OF EXPENSES | 36864 | 11 |
| 12 | PARKING LOT RECEIPTS | | 12 |
| 13 | REVENUE FROM LAUNDRY AND LINEN SERVICE | | 13 |
| 14 | REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS | 26013 | 14 |
| 15 | REVENUE FROM RENTAL OF LIVING QUARTERS | | 15 |
| 16 | REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS | | 16 |
| 17 | REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS | | 17 |
| 18 | REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS | 5742 | 18 |
| 19 | TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) | | 19 |
| 20 | REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN | | 20 |
| 21 | RENTAL OF VENDING MACHINES | 18616 | 21 |
| 22 | RENTAL OF HOSPITAL SPACE | 11200 | 22 |
| 23 | GOVERNMENTAL APPROPRIATIONS | | 23 |
| 24 | MISCELLANOUS | 17792 | 24 |
| 24.01 | GRANTS | 37230 | 24.01 |
| 25 | TOTAL OTHER INCOME | 153999 | 25 |
| 26 | TOTAL | 89373 | 26 |
| 27 | | | 27 |
| 28 | | | 28 |
| 29 | | | 29 |
| 30 | TOTAL OTHER EXPENSES | | 30 |
| 31 | NET INCOME (OR LOSS) FOR THE PERIOD | 89373 | 31 |

RHC I

WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT NO: 14-3479

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

| | | COMPEN-SATION 1 | OTHER COSTS 2 | TOTAL 3 | RECLASSIFI-CATIONS 4 | RECLASSIFIED TRIAL BALANCE 5 | ADJUST-MENTS 6 | NET EXPENSES FOR ALLOCATION 7 | |
|---|---|---|---|---|---|---|---|---|---|
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | | | |
| 1 | PHYSICIAN | 317195 | 29659 | 346854 | | 346854 | | 346854 | 1 |
| 2 | PHYSICIAN ASSISTANT | 35000 | 2819 | 37819 | | 37819 | | 37819 | 2 |
| 3 | NURSE PRACTITIONER | 69000 | 9281 | 78281 | | 78281 | | 78281 | 3 |
| 4 | VISITING NURSE | | | | | | | | 4 |
| 5 | OTHER NURSE | 176576 | 20168 | 196744 | | 196744 | | 196744 | 5 |
| 6 | CLINICAL PSYCHOLOGIST | | | | | | | | 6 |
| 7 | CLINICAL SOCIAL WORKER | | | | | | | | 7 |
| 8 | LABORATORY TECHNICIAN | | | | | | | | 8 |
| 9 | OTHER FACILITY HEALTH CARE STAFF COSTS | 86874 | 8519 | 95393 | | 95393 | | 95393 | 9 |
| 10 | SUBTOTAL (SUM OF LINES 1-9) | 684645 | 70446 | 755091 | | 755091 | | 755091 | 10 |
| | COSTS UNDER AGREEMENT | | | | | | | | |
| 11 | PHYSICIAN SERVICES UNDER AGREEMENT | | | | | | | | 11 |
| 12 | PHYSICIAN SUPERVISION UNDER AGREEMENT | | | | | | | | 12 |
| 13 | OTHER COSTS UNDER AGREEMENT | | | | | | | | 13 |
| 14 | SUBTOTAL (SUM OF LINES 11-13) | | | | | | | | 14 |
| | OTHER HEALTH CARE COSTS | | | | | | | | |
| 15 | MEDICAL SUPPLIES | 158 | | 158 | | 158 | | 158 | 15 |
| 16 | TRANSPORTATION (HEALTH CARE STAFF) | 338 | | 338 | | 338 | | 338 | 16 |
| 17 | DEPRECIATION-MEDICAL EQUIPMENT | 21509 | | 21509 | | 21509 | | 21509 | 17 |
| 18 | PROFESSINAL LIABILITY INSURANCE | | | | | | | | 18 |
| 19 | OTHER HEALTH CARE COSTS | 13458 | | 13458 | | 13458 | | 13458 | 19 |
| 20 | ALLOWABLE GME COSTS | | | | | | | | 20 |
| 21 | SUBTOTAL (SUM OF LINES 15-20) | 35463 | | 35463 | | 35463 | | 35463 | 21 |
| 22 | TOTAL COSTS OF HEALTH CARE SERVICES | 720108 | 70446 | 790554 | | 790554 | | 790554 | 22 |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | | | |
| 23 | PHARMACY | | | | | | | | 23 |
| 24 | DENTAL | | | | | | | | 24 |
| 25 | OPTOMETRY | | | | | | | | 25 |
| 26 | ALL OTHER NONREIMBURSABLE COSTS | | | | | | | | 26 |
| 27 | NONALLOWABLE GME COSTS | | | | | | | | 27 |
| 28 | TOTAL NONREIMBURSABLE COSTS | | | | | | | | 28 |
| | FACILITY OVERHEAD | | | | | | | | |
| 29 | FACILITY COSTS | 83839 | 27503 | 111342 | | 111342 | | 111342 | 29 |
| 30 | ADMINISTRATIVE COSTS | 843 | | 843 | | 843 | | 843 | 30 |
| 31 | TOTAL FACILITY OVERHEAD | 84682 | 27503 | 112185 | | 112185 | | 112185 | 31 |
| 32 | TOTAL FACILITY COSTS | 804790 | 97949 | 902739 | | 902739 | | 902739 | 32 |

RHC I

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT NO: 14-3479

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

| | | NUMBER OF FTE PERSONNEL 1 | TOTAL VISITS 2 | PRODUCTIVITY STANDARD 3 | MINIMUM VISITS 4 | GREATER OF COL. 2 OR COL. 4 5 | |
|---|---|---|---|---|---|---|---|
| 1 | PHYSICIANS | 1.75 | 7168 | 4200 | 7350 | | 1 |
| 2 | PHYSICIAN ASSISTANTS | 0.49 | 1304 | 2100 | 1029 | | 2 |
| 3 | NURSE PRACTITIONERS | 0.90 | 2634 | 2100 | 1890 | | 3 |
| 4 | SUBTOTAL | 3.14 | 11106 | | 10269 | 11106 | 4 |
| 5 | VISITING NURSE | | | | | | 5 |
| 6 | CLINICAL PSYCHOLOGIST | | | | | | 6 |
| 7 | CLINICAL SOCIAL WORKER | | | | | | 7 |
| 8 | TOTAL FTEs AND VISITS | 3.14 | 11106 | | | 11106 | 8 |
| 9 | PHYSICIAN SERVICES UNDER AGREEMENTS | | | | | | 9 |

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

| | | | |
|---|---|---|---|
| 10 | TOTAL COSTS OF HEALTH CARE SERVICES | 790554 | 10 |
| 11 | TOTAL NONREIMBURSABLE COSTS | | 11 |
| 12 | COST OF ALL SERVICES (EXCLUDING OVERHEAD) | 790554 | 12 |
| 13 | RATIO OF RHC/FQHC SERVICES | 1.000000 | 13 |
| 14 | TOTAL FACILITY OVERHEAD | 112185 | 14 |
| 15 | PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY | 339751 | 15 |
| 16 | TOTAL OVERHEAD | 451936 | 16 |
| 17 | ALLOWABLE GME OVERHEAD | | 17 |
| 18 | SUBTRACT LINE 17 FROM LINE 16 | 451936 | 18 |
| 19 | OVERHEAD APPLICABLE TO RHC/FQHC SERVICES | 451936 | 19 |
| 20 | TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES | 1242490 | 20 |

RHC I
COMPONENT NO: 14-3479

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC [ ] TITLE V [ XX ] TITLE XVIII [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

| | | | |
|---|---|---|---|
| 1 | TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES | 1242490 | 1 |
| 2 | COST OF VACCINES AND THEIR ADMINISTRATION | 3329 | 2 |
| 3 | TOTAL ALLOWABLE COST EXCLUDING VACCINE | 1239161 | 3 |
| 4 | TOTAL VISITS | 11106 | 4 |
| 5 | PHYSICIANS VISITS UNDER AGREEMENT | | 5 |
| 6 | TOTAL ADJUSTED VISITS | 11106 | 6 |
| 7 | ADJUSTED COST PER VISIT | 111.58 | 7 |

| | | CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1 | ON OR AFTER JANUARY 1 2 | (SEE INSTR.) 3 | |
|---|---|---|---|---|---|
| 8 | PER VISIT PAYMENT LIMIT | 72.76 | 87.89 | | 8 |
| 9 | RATE FOR PROGRAM COVERED VISITS | 111.58 | 111.58 | | 9 |

CALCULATION OF SETTLEMENT

| | | | | | |
|---|---|---|---|---|---|
| 10 | PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES | 2973 | 991 | | 10 |
| 11 | PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES | 331727 | 110576 | | 11 |
| 12 | PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES | | | | 12 |
| 13 | PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES | | | | 13 |
| 14 | LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES | | | | 14 |
| 15 | GRADUATE MEDICAL EDUCATION PASS THROUGH COST | | | | 15 |
| 16 | TOTAL PROGRAM COST | | | 442303 | 16 |
| 16.01 | PRIMARY PAYOR PAYMENTS | | | | 16.01 |
| 17 | LESS: BENEFICIARY DEDUCTIBLE | | | 35073 | 17 |
| 18 | NET PROGRAM COST EXCLUDING VACCINES | | | 407230 | 18 |
| 19 | REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE | | | 325784 | 19 |
| 20 | PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION | | | 2591 | 20 |
| 21 | TOTAL REIMBURSABLE PROGRAM COST | | | 328375 | 21 |
| 22 | REIMBURSABLE BAD DEBTS | | | | 22 |
| 22.01 | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES | | | | 22.01 |
| 23 | OTHER ADJUSTMENTS | | | | 23 |
| 24 | NET REIMBURSABLE AMOUNT | | | 328375 | 24 |
| 25 | INTERIM PAYMENTS | | | 226777 | 25 |
| 25.01 | TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY) | | | | 25.01 |
| 26 | BALANCE DUE COMPONENT/PROGRAM | | | 101598 | 26 |
| 27 | PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2 | | | | 27 |

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

PROVIDER NO. 14-1328 HARDIN COUNTY GENERAL HOSPITAL
PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05
08/20/2008 09:19

WORKSHEET M-4

RHC I
COMPONENT NO: 14-3479

## COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC [ ] TITLE V [ XX ] TITLE XVIII [ ] TITLE XIX

| | | PNEUMOCOCCAL 1 | INFLUENZA 2 | |
|---|---|---|---|---|
| 1 | HEALTH CARE STAFF COSTS | 755091 | 755091 | 1 |
| 2 | RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME | 0.000186 | 0.002472 | 2 |
| 3 | PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST | 140 | 1867 | 3 |
| 4 | MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE | 8 | 103 | 4 |
| 5 | DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE | 148 | 1970 | 5 |
| 6 | TOTAL DIRECT COST OF THE FACILITY | 790554 | 790554 | 6 |
| 7 | TOTAL OVERHEAD | 451936 | 451936 | 7 |
| 8 | RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST | 0.000187 | 0.002492 | 8 |
| 9 | OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE | 85 | 1126 | 9 |
| 10 | TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION | 233 | 3096 | 10 |
| 11 | TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS | 31 | 412 | 11 |
| 12 | COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION | 7.52 | 7.51 | 12 |
| 13 | NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES | 20 | 325 | 13 |
| 14 | MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | 150 | 2441 | 14 |
| 15 | TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | | 3329 | 15 |
| 16 | TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | | 2591 | 16 |

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER
FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I
COMPONENT NO: 14-3479

WORKSHEET M-5

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

| DESCRIPTION | | | PART B 1 MM/DD/YYYY | PART B 2 AMOUNT | |
|---|---|---|---|---|---|
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | | | 226777 | 1 |
| 2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO. | | | | NONE | 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM TO PROVIDER | .01 | | | 3.01 |
| | | .02 | | | 3.02 |
| | | .03 | | NONE | 3.03 |
| | | .04 | | | 3.04 |
| | | .05 | | | 3.05 |
| | | .50 | | | 3.50 |
| | PROVIDER TO PROGRAM | .51 | | | 3.51 |
| | | .52 | | NONE | 3.52 |
| | | .53 | | | 3.53 |
| | | .54 | | | 3.54 |
| SUBTOTAL | | .99 | | | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | | | 226777 | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM TO PROVIDER | .01 | | | 5.01 |
| | | .02 | | NONE | 5.02 |
| | | .03 | | | 5.03 |
| | | .50 | | | 5.50 |
| | PROVIDER TO PROGRAM | .51 | | NONE | 5.51 |
| | | .52 | | | 5.52 |
| SUBTOTAL | | .99 | | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO PROVIDER | .01 | | 101598 | 6.01 |
| | PROVIDER TO PROGRAM | .02 | | | 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | | 328375 | 7 |

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

| MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES | | 14-3479 | CLINIC NAME Hardin County Rural Health Clinic | | REPORTING PERIOD FROM: 1-Apr-07 TO: 31-Mar-08 | | ATTACHMENT #1 |
|---|---|---|---|---|---|---|---|
| | COST CENTER (OMIT CENTS) | COMPENSATION 1 | OTHER 2 | TOTAL COL.1&2 3 | RECLASSI-FICATIONS 4 | RECLASSIFIED TRIAL BALANCE COL.3&4 5 | ADJUSTMENTS INCREASES (DECREASES) 6 | NET EXPENSES COL.5&6 7 |
| 1 | SUPPLEMENTAL COSTS | | | | | | | |
| 2 | Pharmacy | | | - | | - | | - |
| 3 | Patient Transportation | | **N/A** | - | | - | | - |
| 4 | Medical Case Management | | | - | | - | | - |
| 5 | Health Education | | | - | | - | | - |
| 6 | Nutrition Counseling | | | - | | - | | - |
| 7 | Others(specify) | | | - | | - | | - |
| 8 | | | | - | | - | | - |
| 9 | | | | - | | - | | - |
| 10 | | | | - | | - | | - |
| 11 | | | | - | | - | | - |
| 12 | Supplemental Subtotal(sum of lines 2 through 11) | - | - | - | - | - | - | - |
| 13 | DENTAL | | | - | | - | | - |
| 14 | NON-ALLOWABLE COST CENTERS | | | - | | - | | - |
| 15 | HM\HK Case Management | | | - | | - | | - |
| 16 | WIC( Women,Infants, & Children) | | | - | | - | | - |
| 17 | Fundraising & Public Relations | | | - | | - | | - |
| 18 | Social Services | | | - | | - | | - |
| 19 | Unlicensed Social Workers | | | - | | - | | - |
| 20 | Others(specify) | | | - | | - | | - |
| 21 | | | | - | | - | | - |
| 22 | | | | - | | - | | - |
| 23 | | | | - | | - | | - |
| 24 | | | | - | | - | | - |
| 25 | Non-Allowable Subtotal(sum of lines 15 - 24) | - | - | - | - | - | - | - |
| 26 | Totals for schedule C (sum of lines 12,13, &25) | - | - | - | - | - | - | - |

NOTE: This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.

| RURAL HEALTH CENTER DENTAL STATISTICS | 14-3479 | CLINIC NAME Hardin County Rural Health Clinic | | REPORTING PERIOD FROM: 1-Apr TO: 31-Mar | | | ATTACHMENT #2 |
|---|---|---|---|---|---|---|---|
| | COST CENTER (OMIT CENTS) | COMPENSATION 1 | OTHER 2 | COL.1&2 3 | RECLASSI-FICATIONS 4 | RECLASSIFIED TRIAL BALANCE (COL.3&4) 5 | ADJUSTMENTS INCREASES (DECREASES) 6 | NET EXPENSES (COL.5&6) 7 |
| 1 | RHC DENTAL STAFF COST | | | | | | | |
| 2 | Dentists | | | - | | - | | - |
| 3 | Dental Hygienist | | **N/A** | - | | - | | - |
| 4 | | | | - | | - | | - |
| 5 | | | | - | | - | | - |
| 6 | TOTAL - Dentists(Sum of lines 1 through 5) | - | - | - | - | - | - | - |
| 7 | Other - Dental Staff | | | - | | - | | - |
| 8 | | | | - | | - | | - |
| 9 | | | | - | | - | | - |
| 10 | | | | - | | - | | - |
| 11 | SUBTOTAL- Other Dental Staff( Sum of lines 7-10) | - | - | - | - | - | - | - |
| 12 | TOTAL - Dental Staff (Sum of lines 6 and 11) | - | - | - | - | - | - | - |
| 13 | Dental Services Under Agreement | | | - | | - | | - |
| 14 | | | | - | | - | | - |
| 15 | TOTAL DENTAL COST(Sum of lines 12 through 14) | - | - | - | - | - | - | - |

DENTAL SERVICES PERSONNEL,EQUIVALENTS,HOURS ON SITE, AND ENCOUNTERS

| | DENTAL SERVICES PERSONNEL | FULL TIME PERSONNEL EQUIVALENTS (FTEs) | HEALTH SERVICES HOURS | ENCOUNTERS | | |
|---|---|---|---|---|---|---|
| | | | | ON-SITE | OFF-SITE | TOTAL |
| | | 1 | 2 | 3 | 4 | 5 |
| 16 | RHC DENTAL STAFF | | | | | |
| 17 | Dentists | | | | | 0 |
| 18 | Dental Hygienist | | | | | 0 |
| 19 | | | | | | 0 |
| 20 | | | | | | 0 |
| 21 | TOTAL - Dentists(Sum of lines 17 through 20) | 0 | 0 | 0 | 0 | 0 |
| 22 | Other - Dental Staff | | | | | 0 |
| 23 | | | | | | 0 |
| 24 | | | | | | 0 |
| 25 | | | | | | 0 |
| 26 | SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25) | 0 | 0 | 0 | 0 | 0 |
| 27 | TOTAL - Dental Staff(Sum of lines 21 and 26) | 0 | 0 | 0 | 0 | 0 |
| 28 | Dental Services Under Agreement | | | | | 0 |
| 29 | | | | | | 0 |
| 30 | TOTAL DENTAL(Sum of lines 27 through 29) | 0 | 0 | 0 | 0 | 0 |

NOTE: Total dental cost from line 15, column 7, must agree with Attachment #1, line 13.